ARTICLE 5

SECTION 4

DDSD REFERRALS

1. GENERAL

This section details the procedures for processing disability referrals. The State Programs-Disability Determination Service Division (SP-DDSD), in the California Department of Health Services (CDHS), is responsible for evaluating medical and employment data to determine if an applicant/beneficiary meets the federal definition of disability. Disability is defined as the "inability to engage in any substantial gainful activity by reason of a medically determinable physical or mental impairment which can be expected to result in death or has lasted or can be expected to last for a continuous period of not less than twelve months..." DDSD does not determine incapacity for AFDC linkage nor verify pregnancy or social security numbers. MEM Proc. 22C-7

Note: Substantial gainful activity does not apply to 250% Working Disabled applicants. ACWDL 00-16

2. WHEN TO REFER TO DDSD

The disability referral process is used only when:

A. The disability cannot be confirmed by the methods detailed in MPG Article 5, Section 3; or

B. The applicant/beneficiary:

1) Has a pending SSI or Social Security Title II application pending with no previous SSA denial within the last 12 months; or State Clarification

2) Was receiving SSI/SSP and was discontinued for a reason other than termination of disability and does not currently receive Social Security Title II disability benefits.

All referrals must be submitted to DDSD within 10 calendar days from the date the statement of facts is received, or from the date the applicant claims to be disabled, whichever is later. The only exception is when circumstances beyond the worker's control cause a delay in submitting the referral. The reasons for the delay must be documented in the case narrative. Do not hold the referral pending evaluation or verification (i.e., property issues) of other non-disability factors. If the client is later found to be ineligible, send form MC 222 (MPG 5-4-7) to inform DDSD. MEM Proc 22C

3. HOW TO IDENTIFY A DDSD REFERRAL

A. Indications of Disability

Potential disability is indicated by any of the following:

1) The applicant/beneficiary has answered "yes" to disability questions on the Statement of Facts.

2) The applicant/beneficiary states on form MC 176S Status Report that he/she is now disabled.

3) The applicant/beneficiary makes a written or oral statement to the worker which alleges disability.

   Form MC 017, "What You Should Know About Your Medi-Cal Disability Application" (Appendix A1), will be given to clients who wish to pursue a Medi-Cal application based on disability. This informational form gives the client an overview of what can be expected when an application based on disability is filed.

B. Disability Evaluation by SSA

MEM Proc 22C

The following are guidelines for referring a client to SSA (see Appendix A2):

1) When SSA has denied disability status within the previous 60 days, the client must ask SSA to "reconsider" a previous denial action, as the client has 60 days to appeal SSA's decision. The worker will deny the Medi-Cal application.

   If the client has a reconsideration request pending with SSA, the worker will deny the Medi-Cal application.

2) When SSA has denied disability status more than 60 days from the SAWS1 date, but within one year of the current date, the client must ask SSA to "reopen" the previous evaluation. SSA may or may not "reopen" the claim. The worker will deny the Medi-Cal application.

   If the client's same condition has changed or worsened, the worker must refer the client back to SSA and deny the Medi-Cal application.

   If SSA denied the disability claim after reopening the previous decision, SSA's decision would be controlling over Medi-Cal. The worker will deny the Medi-Cal application.

3) When SSA has denied the claim more than one year before the current SAWS1 date and the client does not allege that the same condition has worsened or that there is a new condition, the client will be asked to file a new application with SSA. The worker will deny the Medi-Cal application.

   Note: See MPG Article 5, Section 4, Item 14D, when a client is referred back to SSA and SSA approves the disability after originally denying the claim. **Applicants who are denied SSA disability status based on the capacity to perform SGA (MEDS INQT screen will show denial codes N31, N32, N33, N42, N44) and who are otherwise eligible for the 250% Working Disabled Program, will be referred to SP-DDSD for a disability evaluation.**

State Clarification

C. Appropriate Referrals

MEM Proc 22C-1

The purpose of a disability evaluation is to establish linkage to the MN program. A disability evaluation is appropriate for:

1) Persons age 18 or over who meet the definition of "federally disabled."

2) Children who appear or allege to be disabled.

3) Any other applicant or recipient who is potentially disabled.

4) Disabled applicants/beneficiaries whose condition the worker believes has improved, or the beneficiary reports an improvement.

5) A disabled beneficiary who becomes employed (in either paid, unpaid, or volunteer work).

6) A disabled beneficiary who goes off Medi-Cal for 12 or more months for any reason other than termination of disability.

7) Disabled applicants under age 65 who do not receive Title II disability benefits and have been discontinued from SSI/SSP for reasons other than termination of disability even though there was no SSA reexamination date.

8) Recipients of County Medical Services (CMS) who request a disability based Medi-Cal evaluation, including those who provide a Medi-Cal Referral, form CMS-5. The CMS-5 form is to be completed by the Medi-Cal worker and forwarded to the CMS worker as indicated on the forms distribution. The eligibility worker must ask the applicant if he/she received CMS services in any of the three retroactive months and include those months on the DDSD transmittal form MC 221.

County Policy

9) Persons who were denied Title II (SSA) or Title XVI (SSI) disability status (Appendix A2):

   a) Within 12 months from the SAWS1 date and have a letter from SSA proving SSA refused to reopen the previous denial.

   b) Within 12 months from the SAWS1 date, claim a new medical condition not considered by SSA and did not reapply with SSA.

   c) More than 12 months from the SAWS1 date, claim the same medical condition has worsened or a new medical condition not considered by SSA and did not reapply with SSA.

NOTE: Workers should not hesitate to tactfully discuss a disability referral with an applicant/beneficiary who does not specifically meet the criteria for referral listed above, but who could be disabled (e.g., client has difficulty walking, standing,

sitting; client seems disoriented to time, place, person; client exhibits extreme emotional distress; etc.). It is to the client's benefit to be evaluated for disability because ABD clients are eligible to larger income deductions. **A physician's verification form is not required to initiate a DDSD referral. If a physician's verification is received, an application that has been identified as a DDSD referral will not be denied based on the responses on the verification.** Any medical verification received must be included with the DDSD referral.

D. Inappropriate Referrals

A disability evaluation is not appropriate for:

1) Persons who, within the last 90 days have had a DDSD determination and were found not disabled or no longer disabled, unless the applicant alleges his/her condition has deteriorated, presents new medical evidence, or claims a new physical and/or mental condition exists.

2) Applicants determined disabled under the MN program within the last twelve months, unless the reexamination date has passed or the applicants indicate their condition has improved.

3) Persons already classified as aged or disabled unless a blindness evaluation for Pickle eligibility is required.

4) Persons who do not meet other eligibility factors, such as California residency or property limits.

5) Applicants who are working and engaged in Substantial Gainful Activity.

6) Person who were denied disability status by SSA (Appendix A2):

- Within 60 days from the SAWS1 date and did not ask SSA to reopen the previous denial;
- Within 12 months from the SAWS1 date, claim the same medical condition has worsened and did not ask SSA to reopen the previous denial;
- Within 12 months from the SAWS1 date and do not claim the same medical condition has worsened or a new medical condition;
- Over 12 months from the SAWS1 date and do not claim the same medical condition has worsened or a new medical condition; or
- Any time they have appealed the SSA denial and the decision is pending.

7) An individual who does not wish to have disability evaluated. Although there are advantages to ABD linkage, a worker cannot require the applicant/recipient to complete an evaluation request.

4. PENDING DISABILITY DETERMINATION AID CODES ACWDL 02-40

A. When a Medi-Cal **beneficiary** (not an applicant) alleging a disability is not currently considered disabled, and other linkage no longer exists, the individual alleging the disability may receive Medi-Cal benefits under a Pending Disability Determination aid

code until a disability determination is made. This applies to beneficiaries who are discontinued from aid code 53 and who have a pending DDSD determination. If the individual meets the criteria in 5-4-3C above, the worker is to initiate a DDSD referral and assign the individual the appropriate Pending Disability Determination aid code from the following: State Clarification

6J–Full scope, zero share of cost
6R-Full scope, share of cost
5J-Restricted scope, zero share of cost
5R-Restricted scope, share of cost

ACWDL 02-40

(See Appendix J for automation grid.)

NOTE: The above aid codes must not be used if the beneficiary:

- is eligible under another Medi-Cal aid code, or
- reports a disability more than 30 days after the discontinuance for loss of linkage. (Beneficiaries who report a disability 31 days or more after Medi-Cal discontinuance are to be instructed to reapply for benefits.)

B. CalWORKs Discontinuances Due to Loss of Linkage/Alleged Disability

When a CalWORKs recipient is discontinued due to loss of linkage and the individual alleges a disability, the aid code (AC) 38 worker must use all other information from the CalWORKs case to establish continuing Medi-Cal eligibility. The only additional information required is the written affirmation of disability (if not documented on the most recent statement of facts or in the case record with a sworn statement) and the completed DDSD packet. The 38 worker shall assign the individual the appropriate pending disability aid code from C. above.

The redetermination date will be aligned with the renewal date of the CalWORKs case.

5. SUBSTANTIAL GAINFUL ACTIVITY (SGA)

Under Section 435.540 of the Code of Federal Regulations (42 CFR), to be considered disabled, an individual must be unable to engage in Substantial Gainful Activity (SGA) due to a physical or mental impairment, which is expected to result in death or last for a continuous 12-month period. An SGA determination will be made when an applicant/recipient applies for Medi-Cal disability and:

- States on the MC 223 that he/she is working and has gross earnings of more than the current monthly SGA limit (see Appendix 11-1-B).
- Meets the criteria for Presumptive Disability (PD) and has gross earnings of more than the current monthly SGA limit. PD will not be approved until an SGA determination is made.

MEM Proc. 22C-2

NOTE: These procedures do not apply to individuals who are blind (totally or by legal definition) and return to work after disability has been approved, or who meet the eligibility requirements for the 250 Percent Working Disabled (WD) Program. If an SGA evaluation was

ACWDL 00-16

not performed because the person alleged blindness and DDSD found that the person was disabled but not blind, an SGA evaluation must be performed before eligibility as a disabled person can be established.

A. SGA Determination (MC 272 form, Appendix B1)

The worker will:

1) Obtain verification of the client's monthly gross earnings. If irregular, earnings will be averaged. Earnings derived from IHSS are treated as earned income.

2) Obtain verification of the client's Impairment-Related Work Expenses (IRWE) (Article 10, Section 6) and/or subsidies (Item 4.B. below).

3) Complete form MC 272 to determine the client's net countable earnings. Note: Insert the current SGA amount. MEM Proc. 22C-12

If the net countable earnings are greater than the current monthly SGA limit, the applicant shall be evaluated for eligibility to the 250 Percent WD Program. If the applicant is found ineligible to the 250 Percent WD Program, has no other linkage and the applicant is engaging in SGA, the Medi-Cal application based on disability will be denied. ACWDL 00-16

If the net countable earnings are equal to or less than the current monthly SGA limit, the applicant is not engaged in SGA. The worker will notate in Item 10 (Comments Section) of the MC 221 "Client was evaluated and is not engaged in SGA" and a copy of the MC 272 must accompany the DDSD packet. ACWDL 02-47

A Work Activity Report from MC 273 (Appendix 5-4-B2-B3) may be given to the applicant to help make a SGA determination. Form MC 273 is available in Spanish. Note: Insert the current SGA amount before providing the MC 273 to the applicant.

Form MC 222 DDSD Pending Information and a copy of the MC 272 must be sent if a disability packet is pending at DDSD, and the client is subsequently found to be engaging in SGA.

B. Subsidies

A subsidy is support an individual receives on the job which could result in more pay than the actual value of the service performed. A subsidy could involve giving the impaired worker the same pay but more supervision or fewer/simpler tasks than other non-impaired workers or result in more pay than the actual work is worth. Workers in sheltered workshops or settings are generally subsidized.

Subsidies will be verified by obtaining a statement or evidence from the employer confirming that a subsidy exists and the value of the subsidy. Subsidies are deducted from gross earnings to determine the "net countable earnings" for SGA eligibility. Subsidies are not considered earned income exemptions when computing budget determinations.

Example: Employer states that the value of a client's work is half the actual earnings. The client earns $800 per month. Because half the work is subsidized, $400 is considered the real value of the work and the client is not engaging in SGA.

NOTE: $800 is the non-exempt income for the worker to use in determining the client's SOC budget.

C. Special Work Considerations

If a client is forced to stop working after a short time due to an impairment, the work is generally considered an unsuccessful work attempt (UWA) and the earnings from that work will not be used to determine SGA. MEM Proc 22C

1) UWA Requirements

All of the following must be present for work to be considered UWA:

a) There is a break in the client's employment of 30 days or more, and
b) Work lasted less than six months, and
c) Work stopped due to client's impairment.

2) Evaluating Unsuccessful Work Attempts

The following are examples of possible situations which might be encountered when evaluating work activity.

EXAMPLE A: Client worked from 12/1/92 to 6/30/94. Work stopped due to his impairment. He returned to work on 8/5/94 and stopped again on 9/1/94.

- There is a break in employment of over 30 days between 6/30 and 8/5.
- Work lasted less than six months from 8/51 to 9/1.
- Work stopped due to client's impairment.

EW's Actions

- In Item 10 of MC 221, indicate "work after 6/94 is an UWA".
- In Item 6 of MC 221, list retro months of 7/94 and 8/94.

EXAMPLE B: Client worked sporadically from 10/93 to 12/93, 3/94 to 4/94 and 6/94 to 7/94 because of his mental illness. He applies on 7/10/94, asking for retro back to 4/94.

Worker's Analysis

- There is a break in employment of over 30 days between each work period.
- Work lasted less than six months for each employment period.
- Work stopped due to client's impairment.

Worker's Actions

- In Item 10 of MC 221, indicate "work prior to application is an UWA."
- In Item 6 of MC 221, list retro months 4/94, 5/94 and 6/94.

EXAMPLE C: Client worked until 5/30/94 and applied on 7/7/94, requesting retro onset to 4/94. CWD determined that client was engaging in SGA in 4/94 and 5/94. In Item 6 of MC 221 that was sent to SP-DDSD, EW Indicated "6/94," and indicated in Item 10 "client engaged in SGA in 4/94 and 5/94." On 8/31/94, client reports a return to work for 8/94 only, but stopped because of her impairment.

Worker's Analysis

- There is a break in employment over 30 days from 5/30 and 8/1.
- Work in 8/94 lasted less than six months.
- Work stopped due to client's impairment.

Worker's Actions

- Complete and send MC 222, DDSD Pending Information Update form to SP-DDSD.
- Indicate in Item 9 that client's return to work in 8/94 was an UWA, and that client is no longer working.

6. INITIATING REFERRALS

There are 2 types of DDSD referrals:

- Limited Referral
- Complete Referral

A. Limited Referral

1) When to Complete

A limited referral packet is required for persons under 65 years of age who were discontinued from Supplemental Security Income (SSI/SSP) for reasons other than termination of disability and who are not currently receiving Title II disability benefits. The worker must take all necessary and available steps to verify the reason applicant was discontinued from SSI/SSP with SSA, MEDS, or IEVS. Verifying the reason for SSI/SSP discontinuance could eliminate the need for a limited referral being sent. This procedure includes those applicants who were entitled to IHSS prior to being discontinued from SSI/SSP due to earnings.

MEM Proc. 22C

MEM Proc. 22C-6

This evaluation is necessary because the SSI/SSP record of disability is maintained for only 12 months following the SSI/SSP discontinuance. After the 12 months has lapsed, any query to Social Security Administration (SSA) will show that the beneficiary is not disabled. Therefore, while eligibility may be granted when verification of disability status with SSA is obtained, ongoing disability status must be established by DDSD prior to the end of the 12-month record retention period.

MEM Proc. 228

All redeterminations will require a limited referral packet unless one of three conditions exist. Those conditions are: it has been more than 12 months since the applicant was discontinued from Medi-Cal; the reexam is due, past due or

MEM Proc. 22C-9

unknown; or the applicant's condition has improved. Under the previous conditions, a complete referral is required.

A limited referral packet will be used for deceased applicants. Any available documentation of death must be included (e.g., death certificate, hospital records, etc.). DHS Clarification

A limited referral packet may be sent for reevaluation determinations only when the packet is sent within 30 days of SP-DDSD's decision or an earlier onset date on an approved case is needed, no new disabling factors are alleged, and no new treatment sources are alleged. If a packet is returned to the County as an incomplete or inaccurate packet and the packet is re-submitted to SP-DDSD within 30 days of SP-DDSD's decision, a copy of the DDSD determination must accompany the reevaluation request. All other reevaluations require a complete packet. ACWDL 02-47

A limited referral may be submitted to SP-DDSD for an IHSS applicant when the receipt of SSI/SSP benefits of the applicant cannot be verified **and** the worker has taken all necessary and available steps to obtain the SSI/SSP status from SSA. ACWDL 05-14

If SP-DDSD is unable to adopt the Federal disability determination, or SSA has not made a disability determination, the limited referral will be returned to the worker and a complete referral packet will be requested.

2) How to Complete

a) Forms Packet

The Limited Packet contains the following items:

(1) MC 221 LA Transmittal Form

i. For discontinued SSI recipients, indicate, in Section 10, the following, "Limited Referral-Craig vs. Bonta case-individual discontinued from SSI effective _____ with code N02." County Policy

ii. For persons discontinued from SSI/SSP due to income or resources, and not in receipt of Title II disability benefits, indicate in Section 10, steps taken to verify the reason for the SSI/SSP discontinuance, and reason if known, why the information was unobtainable. MEM Proc. 22C-6

iii. For IHSS applicants, list in Section 10, steps taken to obtain SSI/SSP status and reason if known, for SSA not providing SSI/SSP status. ACWDL 05-14

iv. Packets received without the appropriate annotation will be returned by SP-DDSD with a Z56 (No Determination Situations).

(2) Copy of prior MC 221 LA form for redeterminations and reevaluations.

(3) Copy of prior DDSD determination.

b) Referral

The completed packet must be sent to SP-DDSD no later than 10 calendar days after form JA2 or MC 210 is received. Attach a route slip stating "to DDSD" to the packet and send it to clerical for mailing to DDSD via U.S. mail.

Clerical mails referrals daily to:

California Department of Social Services
Disability and Adult Program Division
Los Angeles State Programs Branch
P.O. Box 30541, Terminal Annex
Los Angeles, CA 90030
(213) 480-6400/8-677-6400 CALNET
FAX (800) 869-0188

B. Complete Referral

1) When to Complete

A complete referral is required for:

a) Medi-Cal beneficiaries 21 through 64 who are potentially disabled.

b) Medi-Cal applicants or beneficiaries who are eligible under another program (Aid to Families with Dependent Children-MN (AFDC-MN) Program, Medically Indigent Child Program, etc.) and who allege disability and want to be evaluated for disability status. A child who is determined to be disabled may have a lower share of cost than an AFDC-MN child because of the greater income deductions available to both the child and his/her parents.

c) Applicants with a Title II or SSI/SSP disability determination pending (including blindness). Indicate the pending determination on form MC 221.

d) Persons determined presumptively disabled. Presumptive eligibility is covered in MPG Article 5, Section 3.

2) How to Complete

a) Forms Packet

A complete packet contains the following forms:

(1) MC 220 Authorization for Release of Information - The worker will obtain a medical release for each treatment source or agency listed on form MC 223. ACWDL 03-32

(2) MC 221 LA Transmittal; and

(3) MC 223 Statement of Facts Regarding Disability; and

(4) DHS 7035A (for adults) or DHS 7035C (for children from birth to the day they turn 18) - Medical Verification - HIV. Workers must send these forms to the client's physicians when the disability is HIV related. MEM Proc. 22C-3

(5) Copy of the death certificate, if available. Do not hold the packet if unavailable. If the packet has already been sent to DDSD, forward with the MC 222.

(6) Copy of the authorized representative (AR) form. If an AR form (or a change of AR notification) is received after the DDSD packet was mailed, a copy of this AR form needs to be sent to SP-DDSD, along with a MC 222 LA. ACWDL 97-01

(7) SSA notice regarding the refusal to reconsider or reopen the client's claim or that the applicant is no longer eligible due to income or resource requirements for SSI.

(8) Any documentation or **medical evidence** that may be helpful in the disability evaluation (i.e., current medical statement, pending appeal of an SSA disability denial, hospital discharge summary) should be included in the packet sent to DDSD.

(9) Copy of the MC 179 90-Day Status Letter (see DDSD Status Letter below). The worker will include a copy of the MC 179 with the packet if it has been issued to the applicant/beneficiary. The MC 179 is sent to the applicant if the packet has not been submitted to SP-DDSD by the 80th day from the SAWS 1 date for new applicants or the MC 223 date for beneficiaries. ACWDL I 00-07

b) Referral

The worker will send the completed packet to DDSD no later than 10 days after the completed Statement of Facts has been received by the worker. The worker will attach a route slip marked "to DDSD" to the packet and send it to clerical for mailing to DDSD via U.S. mail. A copy of the DDSD packet must be filed in the case. County Policy

C. DDSD Status Letter

A status letter, MC 179 (Appendix A3), must be sent to each applicant whose referral packet has not been submitted to the SP-DDSD by the 80th day from the date of the SAWS 1 for new applicants. Referral packets submitted to the SP-DDSD after the 80th day must include a copy of the MC 179 and the worker must indicate on the MC 221, item 10, that an MC 179 has been submitted. ACWDL 03-32 MEM Proc. 22C-8

If a referral packet is received by the DDSD on or after the 86th day without a copy of the MC 179, DDSD will send a letter informing the worker that the MC 179 is missing. The worker is required to immediately send the MC 179 and forward a copy to DDSD. Referral packets returned by DDSD for missing or incomplete information and received back by DDSD after the 85th day must also include a copy of the MC 179 and the worker must check the box in item 10 of the MC 221 that an MC 179 has been submitted.

7. FORMS COMPLETION

A. MC 220 - Authorization for Release of Information (04/03) (Appendix 5-4-C1 and C2) ACWDL 03-32

1) Purpose

The MC 220 authorizes the release of medical records, education records and other information related to the ability to perform tasks. Medical records include testing and treatment records for medical conditions including Human

Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), or AIDS-Related Complex (ACR) patients. ACWDL 03-32

A signed and dated MC 220 is required for each treatment source or agency listed on the MC 223 with the exception of Social Security. A relevant source is one who has treated or seen the applicant for a significant medical problem(s).

Improperly completed MC 220s will be returned because treatment sources will refuse to release medical records without a properly completed, unaltered medical release. Confidentiality of medical records is required by the federal Privacy Act, state Civil Code, Section 56.13(a), and Medi-Cal regulations.

2) Completion

Eligibility workers will complete the top portion of the form including the name, Social Security number and date of birth of the DDSD applicant. The following information pertains to the completion of the MC 220 by the DDSD applicant.

a) The MC 220 is currently available in English and Spanish.

b) A signed and dated release of information form is valid for one year from the date signed.

c) If the release of information is for a minor age twelve and over, who is living with his/her parents, the minor must sign the release in addition to a separate release signed by the parent. (Does not apply to Minor Consent applicants.)

d) If the release of information is for a minor age twelve and over, whose disability is linked to services available through the Minor Consent Program, the minor must sign the release and check the "Minor Consent Services Only" box.

e) The MC 220 may be signed by the applicant, the legal representative of a minor or incompetent applicant, or the personal representative of a deceased applicant. If the applicant is physically or mentally incompetent and the release is completed by another individual in accordance with the instructions in (1) and (2) below, most providers will accept the release and provide the requested information.

(1) If the applicant has a guardian or conservator, the release must include the signature of the guardian or conservator and the relationship to the applicant, i.e., legal guardian.

(2) If the applicant is incompetent (this includes minors, except for minor consent services) or physically incapable of signing, and does not have a guardian or conservator, the release may be signed by the legal representative who is acting on the applicant's behalf, and must include the relationship to the applicant (i.e., spouse, mother, friend) and the reason the applicant cannot sign the release.

f) Signature by a witness is required if the individual authorizing the release of information signs with a mark, such as an "X" or other unrecognizable format (i.e., non-English characters) or if the signature is illegible. Witnessed signatures include: ACWDL 03-32

(1) The signature or mark of the applicant;

(2) The applicant's name, written next to the "X" by the witness;

(3) The signature of a witness and date of signature. NOTE: Witness signatures with an "X" or other unrecognizable format are not acceptable because the treating source will be unable to read or verify the signature; and

(4) The complete address of the witness.

g) A signed Authorized Representative (AR) form granting another person the authority to act on behalf of the applicant during the Medi-Cal application process does not permit, in itself, the AR to sign medical releases or discuss the applicant's case with DDSD. DDSD will not contact or answer questions for such ARs regarding the applicant's case. However, when the applicant signs the AR form, he/she may include a statement at the bottom of the form granting the authority to sign medical releases. The applicant must sign his/her name under that statement. This authorizes the AR to sign medical releases and discuss the case with DDSD.

B. MC 221 LA - Disability Determination and Transmittal (Appendix 5-4-D)

1) Purpose

The MC 221 LA is the transmittal and determination form shared between HSSA and the State DDSD. It is used only for new applications or resubmitted cases to DDSD. Staff must clearly print all information given on the MC 221. ACWDL 00-46

NOTE: If a case is pending in DDSD, DO NOT use the MC 221 to update DDSD regarding any changes or to provide new information. Use MC 222 - DDSD Pending Information Update form instead.

2) Completion

a) Case Number - Enter San Diego County identification number 37, the Medi-Cal aid code, and the case number in the boxes provided.

b) Boxes 1-4 - Enter the applicant's/beneficiary's first, middle and last name, sex, DOB, and Social Security Number. Only a verified Social Security number is to be entered. Otherwise, it should be left blank and the box for pending or none should be checked. Do not enter a county assigned pseudo number.

c) Box 5 - The month, day and year must be provided. For an applicant enter the SAWS1 date or if currently on Medi-Cal, the date the applicant/beneficiary made the oral or written statement that he/she is disabled.

d) Box 6 - List each month for which retroactive coverage is requested.

e) Box 7 - Enter the applicant's/beneficiary's mailing address and home phone number or the phone number where a message may be left. Often DDSD must contact applicants to schedule consultative exams before making a disability decision. If the applicant/beneficiary moves before a disability decision is made, the worker must report a change of address to DDSD by sending form MC 222.

f) Box 8 - Check the box(es) which identifies the reason for the referral. If more than one box is checked, provide an explanation in Item 10. Descriptions of the referrals are on the back of copy four of the MC 221. If the applicant/beneficiary requests Medi-Cal coverage for months prior to the application month, check "Retro Onset." DDSD will evaluate the onset of disability for each month listed in box 6. (See 5-4-9 for information on retroactive applications.)

g) Box 9 - Check if the applicant is currently a hospital in-patient and identify the hospital. Notify DDSD when the applicant/beneficiary is discharged. If discharged to an address other than their home address, also notify DDSD of the address change on form MC 222.

h) Box 10 - This box is used to relay to DDSD any information that will help DDSD determine disability and for worker observations about a physical and/or mental condition of the disability. ACWDL 02-47

(1) Important information which should be documented includes:

- An applicant already has linkage through another Medi-Cal Program (the analyst will not have to issue a 90-day status letter to an individual who is a Medi-Cal beneficiary).
- The applicant is working and his/her earnings are under SGA (include a copy of the MC 272).
- The applicant is applying under the 250 Percent Working Disabled Program.
- The applicant has been contacted and has agreed to cooperate on a case, which SP-DDSD previously returned to the County due to non-cooperation.
- Applicant insists on applying for a retroactive period even though the applicant had no treatment sources listed during that time period.
- The hospital address where the applicant/beneficiary is an inpatient as well as checking “yes” in box 9.
- Any request for an expedited evaluation is entered here. Such

requests are limited to highly unusual circumstances in extreme emergencies. ACWDL 02-47

(2) Worker observations that will help DDSD make a disability determination include the following:

- Observations about the applicant's physical appearance or mental status; for example, loss of limb, hard of hearing, disoriented, etc. This could be a deciding factor or trigger another area of medical evaluation.
- The name and phone number of a friend or relative who can act as a translator for DDSD when the applicant/beneficiary does not speak English. This information is especially important when the applicant/ beneficiary speaks a language for which a translator is difficult to find.
- If the applicant is receiving or has applied for disability under another Social Security number, enter the other Social Security Number.

This list is not all-inclusive. Worker comments and observations are strongly encouraged. Please provide any relevant input.

If an MC 179 is attached, check “90-Day Status Letter attached” box. If presumptive disability (PD) was granted, check the “Presumptive Disability approved” box.

i) Box 11 - Enter the name and phone number of the worker completing the form.

j) Box 12 - Enter the date from the MC 221 and packet are sent to DDSD.

k) Boxes 13-17 - DDSD completes these boxes. Item 8 of this section titled "DDSD Response" contains information for these boxes. ACWDL 00-46

NOTE: On the bottom of the MC 221, there are boxes indicating "Oakland" and "Los Angeles." When an MC 221 is received by DDSD, DDSD will send a copy of the MC 221 back to DSS with one of the boxes checked to inform DSS where the referral packet is located.

C. MC 223 - Applicant's Supplemental Statement of Facts for Medi-Cal
(Appendix 4-5-E1 through E8)

1) Purpose

Form MC 223 contains information used by DDSD to determine an applicant's ability to work and must be as complete as possible. Form MC 223 is designed for completion by the applicant, but the applicant's representative or the **worker should assist the applicant/beneficiary as needed**. It is available in both

Spanish and English. The MC 223 form may be completed by one of three methods, at the beneficiary's request: ACWDL 02-40

- Through the mail;
- During a face-to-face interview; or
- During a telephone interview (worker completes MC 223 and mails forms to beneficiary to be signed, dated and returned).

2) Completion

All questions must be answered, however, the following items are essential in the disability evaluation process and should be brought to the applicant's/beneficiary's attention. Forms which are incomplete or incorrect may cause delays or be rejected by DDSD.

a) Part 1 - Personal Information

(1) Item 1a - Provide client's full name.

(2) Item 1b - Social Security Number **MUST** be included on **ALL** cases in which the client has a valid Social Security Number. If no Social Security Number exists, indicate "Pending" or "N/A" (applies also to undocumented aliens/amnesty cases).

(3) Item 1c - Complete date of birth, including year **MUST** be included.

(4) Item 1d - Provide all known alias(es).

(5) Item 1e - Indicate sex.

(6) Item 1f-1g - Provide height in feet and inches and weight in pounds, this is vital information in certain types of disability.

(7) Item 2a-2b - Provide address of residence and where correspondence can be mailed if mail cannot be sent to place of residence.

(8) Item 3 - Indicate if client has NO phone or has phone number where messages can be left. Indicate if there is best time to call during normal working hours.

(9) Item 4a-4d - Indicate if client speaks English; if not, give interpreter's name and telephone number.

b) Part II - Medical Information

(1) Item 5-5d - Indicate if client applied for Social Security Disability within the past two years. (See Appendix A2)

If "no," submit disability packet to DDSD.

If "yes," (refer to Appendix A2) determine status of SSA's disability claim:

- Did SSA approve claim?
- Did SSA deny claim, or is status unknown or pending?
- Was decision made within or more than 12 months of the Medi-Cal application?
- Was SSA's denial appealed?

(a) If SSA has approved disability benefits and verification has been made, and if otherwise eligible, grant Medi-Cal benefits as a MN disabled.

(b) If an INITIAL SSA disability application is pending, submit disability packet to DDSD.

(c) If client does not know if he/she has filed an SSA disability application or the status of an SSA application, submit disability packet to DDSD.

(d) If an SSA disability denial determination is on appeal, refer client to SSA. Do not submit disability packet to DDSD.

(e) Has the client's condition worsened since the most recent SSA denial decision?

If "no," refer to SSA. SSA disability decisions are binding. Do not submit the disability packet to DDSD.

If "yes," determine how long since the most recent SSA denial decision has been made.

Less than 12 months of the Medi-Cal application, refer to SSA for reconsideration or reopening. Do not submit disability packet to DDSD.

More than 12 months of the Medi-Cal application, AND client has not reapplied to SSA for a reconsideration or reopening, submit disability packet to DDSD.

(2) Item 6 - Indicate what medical condition prevents work activity or limits activities of daily living, including

treated and untreated conditions. Attach additional pages, if needed.

(3) Item 7-8 - Indicate any **HOSPITAL OR CLINIC** where treatment was received. Enter **COMPLETE** name(s) and address(es). Include ZIP Codes. Include patient, clinic or member numbers when applicable. Current telephone numbers including area codes are essential.

NOTE: If client is unable to provide address and address cannot be obtained despite diligent efforts, clearly state this in the address line or county use margin, so DDSD will know it was not inadvertently omitted. DO NOT leave blank.

If client has been seen at additional clinics or hospitals, complete page 8 (additional MC 220's **MUST** be completed for every additional treating source indicated).

NOTE: A separate MC 220 (Authorization for Release of Medical Information) **MUST** be completed for every source of medical information listed on the MC 223. Check boxes are provided in the margin of the form to assist the worker in assuring that all necessary MC 220's have been completed.

(4) Item 9 - Indicate any **DOCTORS** seen **OUTSIDE OF** the hospitals or clinics listed in items 7 through 8. Enter **COMPLETE** name(s) and address(es). Include Zip Codes. Current telephone numbers including area codes are essential. Include complete addresses of any doctor who is out of state/county.

NOTE: If client is unable to provide address and address cannot be obtained despite diligent efforts, clearly state this in the address line or county use margin, so DDSD will know it was not inadvertently omitted, **DO NOT** leave blank.

If client has been seen by additional doctors, complete page 8 (additional MC 220's **MUST** be completed for every additional treating source indicated).

(5) Item 10 - Enter all testing performed. If purpose or name of test is unknown, enter "Unknown test" in "Other" and give name and address of test facility and date.

NOTE: If additional tests are performed, complete bottom of page 8 (MC 220's **MUST** be completed for **EACH** testing facility listed).

(6) Item 12 - List third party sources who know client well. They will be contacted if DDSD needs to clarify client's ability to function.

(7) Item 13 - At times, client may be required to attend a consultative medical examination (CE). Indicate whether client is willing to go to CE which is paid for by DDSD.

c) Part III - Social and Educational Information

(1) Item 14 - Indicate what client does on a day-to-day basis and how daily activities are affected by client's condition(s). This helps DDSD determine the extent of the condition(s) and the effect(s) on client's ability to function, especially in mental or emotional disorders.

(2) Item 15a - Indicate highest grade completed. Indicate if client passed GED.

(3) Item 15b - Indicate when client finished school or when GED was completed.

(4) Item 15c - Indicate if client participated in special education classes.

NOTE: Be aware of inconsistencies (i.e., the client indicates that he/she had completed the eighth grade but has significant difficulties reading, writing or understanding). Inform DDSD if any inconsistencies exist by indicating this on the right margin of the MC 223 or comments section of the MC 221.

(5) Item 16 - Indicate employment within the last 15 years. If work was performed during the past 15 years, complete Part IV of form.

d) Part IV - Work History

(1) Item 17 - Enter job title and dates worked. Provide job description, as job performed may differ from what is described in the Dictionary of Occupational Titles (DOT) which lists jobs performed in the national economy. If no description is provided by client, DDSD will use DOT's job description.

If more than two jobs were performed in the last 15 years, give client extra copies of "Part IV - Work History" to complete.

(2) **What To Include In Job Description**:

- Types of tools, machines or equipment used;
- Whether writing or supervisory duties were involved;
- Frequency and weight of lifting involved;
- Hours spent sitting, standing and walking;
- Other exertional requirements, such as climbing or bending;
- Description of alterations made to job functions to accommodate impairments, such as special equipment or changes in duties; and
- Whether the client's condition(s) made it necessary to stop working and, if so, when this occurred

e) Part V - Signature and Certification

Enter proper signature(s). Enter current date.

8. WORKER ACTION/ELIGIBILITY REQUIREMENTS PENDING RESPONSE ACWDL 02-40

A. Medi-Cal Eligible Pending DDSD Evaluation

1) If the applicant has linkage to AFDC, ABD, or MI Medi-Cal the worker must grant the case using the appropriate aid code and linkage factor. Enter on line L "DDSD sent (date)."

NOTE: For Presumptive Disability Eligibility do not use AFDC Presumptive Positive Action codes, because those codes do not transmit to MEDS, and the Medi-Cal card will not be produced.

2) If a **beneficiary** alleging a disability is receiving Medi-Cal under a Pending Disability Determination aid code, do not use the ABD income deductions when calculating the budget. Instead, use the Medically Indigent income deductions. Enter “Alleges Disability” on the priority line. ACWDL 02-40

3) The beneficiary must continue to meet all other Medi-Cal eligibility requirements while the DDSD is pending. For example, the redetermination must be completed if it comes due while the DDSD is pending.

B. Medi-Cal Ineligible Pending DDSD Evaluation

DDSD or SSI/SSP pending applicants, other than those in item 7A above, will be referred to County Medical Services (CMS). MPG Article A describes the CMS Program.

All pending DDSD cases will be assigned one worker number as determined by the district.

C. Communication With DDSD

It is the responsibility of the worker to notify DDSD of any changes in the applicant's status while DDSD is in the process of making a disability determination. It is important to send form MC 222 LA (Appendix F) immediately when any of the following occur: MEM Proc. 22C-3

1) SSA decision made. A copy of the SSA document regarding benefits, or the SSA denial letter and personalized denial notice will be attached to the MC 222 LA.

2) Change in applicant's/beneficiary's address.

3) Change of applicant's/beneficiary's name or telephone number, including message number. If the applicant moves out of state, indicate that the disability evaluation is still needed through the month the applicant moved out of state and keep case in pending status. (See 11 below for instructions related to incarceration.) State Clarification

4) Denial or discontinuance of the applicant/beneficiary on the basis of nonmedical information, i.e., excess property, etc.

5) Withdrawal of the application.

6) Cancellation of the Authorization for Release of Information (form MC 220) by the applicant/beneficiary.

7) The death of the applicant. Attach a copy of the death certificate, death notes or death summary to the MC 222 LA, if available. County Policy

8) Receipt of new medical evidence (attach new medical evidence to MC 222 LA).

9) Availability of interpreter (provide name and phone number).

10) Receipt of a new authorized representative (AR) form, or report of change of an AR.

11) Applicant becomes incarcerated (include date of incarceration, name, address, and phone number of facility). Indicate that the disability evaluation is still needed for the months beginning with any retroactive months through the month of incarceration. **The case must remain in pending status while the DDSD evaluation is completed and the case must be flagged to discontinue the month of incarceration if disability status is approved.** State Clarification

12) Any other information which may affect DDSD's actions on the pending case.

If the applicant/beneficiary is denied or discontinued before DDSD makes a decision, the worker must hold the closed case file until the DDSD response on form MC 221 is received.

9. DDSD RESPONSE

A. Disability Not Approved

1) DDSD Action

The DDSD analyst will return the MC 221 with the disability determination attached when the applicant/beneficiary does not meet MN disability criteria based on DDSD's vocational and medical evaluation. DDSD will attach a notice (rationale) explaining the basis for their determination. The worker must attach the rationale to the denial or discontinuance Notice of Action or the NOA will be invalid. Do not send a copy of form MC 221. ACWDL 00-46

2) Worker Action

If PD has been granted, DDSD subsequently adopts SSA's disability denial and the beneficiary files an appeal with SSA, benefits will continue through the appeal process. DDSD will indicate Code "Z53" on the MC 221 if SSA's denial is adopted. DHS Clarification

If PD has not been granted or the PD individual has not appealed SSA's denial, the worker will evaluate eligibility under any other Medi-Cal linkage. If disability is the only linkage to Medi-Cal, the applicant/beneficiary will be denied. The worker will:
The worker will:

a) Deny the case.
b) Attach the DDSD rationale which explains the basis of the determination to the denial NOA and mail it to the applicant/beneficiary.
c) File a copy of the NOA and the DDSD rationale in the case record.
d) Send form 14-10 DSS to notify the CMS Program of the Medi-Cal denial if the applicant/beneficiary was certified CMS pending the disability evaluation.
e) Send a photocopy of form MC 221 to the GR worker if the applicant/ beneficiary currently receives GR.
f) For applicants who are eligible to Medi-Cal under another linkage, see Appendix J for the appropriate NOA.

B. Disability Granted By DDSD

1) DDSD Action

DDSD will attach the disability evaluation results to the MC 221. If the SP-DDSD determines the applicant is disabled, then the applicant is disabled under MN criteria. The onset date provided will take into consideration any request for up to three months retroactive coverage prior to the date of application as long as the worker has requested retro onset on form MC 221. ACWDL 00-46

2) Worker Action

If DDSD has determined that the applicant/beneficiary is disabled, the worker will approve the application as disabled or reclassify the beneficiary as disabled MN.

a) Statement of Facts

It is the responsibility of the applicant/beneficiary to report changes in "facts pertinent to the determination of eligibility and share of cost within 10 calendar days..."

When granting an application that has been pending with DDSD, the worker may update case information by either of the following methods:

(1) Having the applicant/beneficiary update the Statement of Facts (form MC 210) and initial each change; or

(2) Having the applicant/beneficiary complete, sign and date a sworn statement.

b) Worker Actions

The approval of eligibility, or reclassification as a disabled MN person will be effective with the disability onset date or application date, as appropriate.

(1) The Medi-Cal worker will send a photocopy of form MC 221 to the General Relief worker when the applicant/beneficiary was referred to Medi-Cal by the GR worker, and

(2) Notify the CMS Program by sending form 14-10 HHSA, and

(3) Set a tickler on the case for referral to DDSD 30 days prior to the re-exam date if one is indicated on form MC 221.

C. DDSD Adopts Social Security Administration (SSA) Allowance

Often the Medi-Cal applicant/beneficiary has also applied for benefits with SSA. The Social Security Administration evaluates the applicant's disability before they evaluate any other eligibility factors. A high percentage of SSI/SSP applications are denied because the applicant does not meet federal disability criteria. In cases where the Medi-Cal applicant has applied for benefits with the SSA and the SSA has completed the disability evaluation, DDSD will "adopt" the SSA's determination. DHS Clarification

1) Social Security Determines the Applicant is Not Disabled

If Social Security has determined the applicant is not disabled, DDSD will return form MC 221 with an attachment indicating the applicant is not disabled. The form will indicate that Social Security has determined the applicant is not disabled. The worker will take the actions instructed in item 8.A., above. ACWDL 00-46

2) Social Security Determines the Applicant is Disabled

If Social Security has determined the applicant is disabled, DDSD will return form MC 221 with an attachment indicating the applicant is disabled and will give the

onset date. This does not mean the applicant/beneficiary is receiving or will receive SSI/SSP benefits. After Social Security determines disability, they review other eligibility factors. This review may take several months and the applicant may be determined ineligible to SSI/SSP. Because the beneficiary receives a Medi-Cal card automatically when he/she receives SSI/SSP benefits, the worker must:

a) Contact the Medi-Cal applicant/beneficiary to determine if he/she has received notification of SSI/SSP eligibility or if he/she is receiving SSI/SSP benefits.

(1) If he/she is receiving SSI/SSP, request the award letter to determine the effective date. Compare the effective date to the Medi-Cal application.

(a) If the SSI/SSP effective date covers all months of Medi-Cal requested, deny or discontinue the Medi-Cal case using code 147 or 090.

(b) If the SSI/SSP effective date is after the months requested, the worker must review the onset date given on form MC 221 and grant Medi-Cal for any months covered by the onset date prior to SSI/SSP eligibility. The granting NOA must indicate that this is for the following months only because the beneficiary is now an SSI/SSP recipient.

(c) Instruct the applicant/beneficiary to request SSI/SSP Medi-Cal cards through clerical for all months in which he/she received medical services not covered by a Medi-Cal case.

(2) If the applicant/beneficiary is not receiving SSI/SSP benefits:

(a) The worker must check MEDS to verify that the applicant/ beneficiary is not coded as an SSI/SSP recipient; and

(b) If MEDS indicates the applicant is an SSI/SSP recipient follow the instructions in item 8.C.2)a)(1), above; and

(c) If MEDS indicates he/she is not an SSI/SSP recipient, grant Medi-Cal as instructed in item 8.B., above.

b) If the beneficiary later receives SSI/SSP, the Medi-Cal case will be discontinued upon notification from the beneficiary or a MEDS worker alert. A 10-day notice is not required in this instance since there is no adverse effect on the beneficiary.

3) Contacting SSA to Verify Disability

If the SP-DDSD's response shows that SP-DDSD adopted a Social Security Administration (SSA) allowance, and the client is not currently receiving SSA Disability benefits, the worker will contact SSA immediately using the form SSA 1610 or 07-94 to determine whether the disability continues. While waiting for the response from SSA the case will be granted based on the SP-DDSD adoption of the SSA allowance.

MEM Proc. 22C-9.2

CDHS Clarif. 10/24/96

If a response is received from SSA indicating that the beneficiary is no longer disabled, a copy of the SSA statement must be sent, along with a MC 221, to SP-DDSD for a reevaluation. Benefits cannot be discontinued unless a SP-DDSD response is received indicating that the beneficiary ceases to be disabled.

MEM 22 C-9.2

D. Disability Cannot Be Determined

DDSD may return form MC 221 indicating they were unable to make a determination. Form MC 221 will state the reason(s) no determination was made and will often request the worker's help in locating the applicant/beneficiary or obtaining the applicant's/ beneficiary's cooperation in attending a consultative exam.

MEM Proc. 22C

1) Failure to Respond/Whereabouts Unknown

a) DDSD Action

If the applicant/beneficiary has not responded to a telephone call and/or mail gram, or if DDSD is unable to locate the applicant/beneficiary, DDSD will not make a disability decision. DDSD will send a form MC 221 requesting help in locating the applicant/beneficiary.

b) Worker Action

If a more current address has been reported, the worker will notify DDSD via form MC 221. If not, the worker will deny or discontinue the applicant/beneficiary for loss of contact if disability is the only basis for Medi-Cal eligibility. See MPG Article 4, Section 13 for instructions when a loss of contact occurs.

2) Withdrawal of Application

a) DDSD Action

If the applicant requests withdrawal of the application for Medi-Cal, DDSD will not make a disability decision. DDSD will notify the worker via form MC 221.

b) Worker Action

The worker will deny the application and send an NOA to the applicant.

3) No Decision

a) DDSD Action

If medical/vocational development has begun, but the evaluation process cannot be completed, DDSD will explain why there is no decision in the "Basis for Determination" section of form MC 221.

b) Worker Action

The worker will deny, discontinue, or determine Medi-Cal eligibility under any other program.

4) Insufficient Information (lack of death certificate, etc.)

a) DDSD Action

DDSD will return the packet to the worker.

b) Worker Action

The worker will attempt to obtain needed information and resubmit the packet to DDSD.

The resubmitted packet must contain a new transmittal form MC 221, and the full contents of the original packet. Updated Release of Information form MC 220 might be necessary, depending on the age of the original referred set. The forms are valid for only 90 days from the date they were signed. If the information cannot be obtained, the worker will deny or discontinue the case.

5) Applicant/Beneficiary Non-Cooperation

a) DDSD Action

If an applicant/beneficiary fails to cooperate with DDSD. DDSD will notify the worker via form MC 221 that they cannot make a determination.

b) Worker Action

The worker must first determine if there is good cause for non-cooperation. Good cause means there is an excusable reason the applicant/beneficiary did not cooperate.

Good cause includes:

(1) Failure of the worker to tell the beneficiary that failure to cooperate with DDSD may result in ineligibility.

(2) Physical or mental illness or incapacity of the applicant which prevents their cooperation.

(3) Failure of the County to properly process the application for disability evaluation.

(4) Unavailability of transportation to complete required actions.

If good cause exists, the worker will resubmit the packet after gaining the applicant's/beneficiary's cooperation. If good cause does not exist, the worker will deny the application using code 142, explaining the reason the applicant is ineligible to ABD-linked Medi-Cal. Beneficiaries eligible to Medi-Cal through another linkage must be told on the NOA 913 why their ABD linkage was denied and that their Medi-Cal eligibility based on the other linkage will continue. CMS recipients who fail to cooperate without good cause will be denied Medi-Cal.

E. Medical Deferment

DDSD can medically defer a case referral for up to three months when future evidence is needed to assess duration and severity of an impairment. Medical deferment is an exception to the rule, rather than a routine procedure. Common reasons are strokes or heart surgery. DDSD will send a copy of the MC 221 form and/or informational form SPB 101 to the county which provides the reason for the medical deferment. MEM Proc 22C

Unless the county receives form MC 221 requesting the worker's help there is no action required on the part of the county. DDSD is only informing the county of a delay in processing the case.

10. RETROACTIVE APPLICATIONS

A. Disabled/Disabled Pending

Retroactive Medi-Cal cannot be granted for disabled or disabled pending applicants until the onset date of disability is determined. Medi-Cal retro can only be granted back to onset date or 3 months prior to the application date, whichever is less.

1) Disabled Applicants

If an applicant with acceptable verification of disability requests retroactive Medi-Cal, and verification of the onset date of disability is not available, the worker will complete form MC 221 and forward it to DDSD to obtain the date of the onset of disability prior to granting retro Medi-Cal. **The worker will indicate in Items 6, 8 and 10 that the applicant is currently disabled and that an earlier onset date of disability is being requested.**

2) Disability Pending

When an applicant is processed as disability pending, the worker cannot grant retroactive Medi-Cal until the disability evaluation is received from DDSD. DDSD will indicate the onset date of disability on form MC 221.

B. Disability Onset Date for Three Months Retroactive Medi-Cal Coverage of SSI/SSP Recipients

MEM Proc. 22C

To request disability onset dates for SSI/SSP disabled or blind recipients who request three-month retroactive Medi-Cal coverage the worker will:

1) Contact the local Social Security Administration (SSA) via form 07-94 to request an onset date. If the onset date provided by SSA is after the month(s) of request for retroactive coverage, a complete referral to DDSD will be necessary.

2) Send the referral with the "Retro Onset" box on form MC 221 checked.

C. Reapplication By Non-Cooperative Persons

MEM 50710

If an applicant has been denied Medi-Cal for non-cooperation and later reapplies for retroactive coverage for the denied month, retroactive Medi-Cal for the retro month in which benefits were denied cannot be granted even if he/she agrees to cooperate with the disability referral process. Regulations prohibit retroactive coverage for a month in which the applicant has been denied for non-cooperation unless the applicant can show, and the worker determines, good cause for lack of cooperation. If, however, an applicant withdraws the application and later files a new application, then continuing and retroactive eligibility is to be determined based on the information provided on the new Statement of Facts as long as that information is reconciled with any information previously provided by the applicant.

11. REEXAMINATIONS

MEM Proc. 22C-9

Reexaminations (reexams) are based on the mandatory date when a beneficiary's medical condition is expected to improve. The reexam date is given by SP-DDSD with their disability evaluation on or attached to the MC 221. The beneficiary will continue to be considered disabled until his/her medical condition improves and has been determined no longer disabled except when the individual refuses to cooperate during the reexaminations. If SP-DDSD allows an initial case that has HIV involvement, they will notate on MC 221R that the case will be exempt from the reexamination process until further notice. Workers must identify these cases indicating that no reexamination is required. Reexaminations are needed when one of the following situations occurs:

ACWDL 06-22

- SP-DDSD set reexamination date is due (see Item 11A);
- SP-DDSD notifies the County DDSD liaison of the cases due for medical reexamination via monthly or 120 days follow-up listings (see Item 11B);
- The worker observes or receives information that the beneficiary's medical condition may have improved.

MEM Proc. 22C-9.2A

Examples:

The beneficiary becomes employed within 12 months from date of application for disability. The beneficiary came in the office using a walker or crutches, but is observed leaving the office without using them; or

- During a case review, the worker notices that the medical reexamination date is past due.

Note: A disability packet is not required if a subsequent Social Security Administration (SSA) determination has found the beneficiary to be disabled and has awarded Title II disability benefits. The federal disability determination is controlling. The beneficiary will continue to receive benefits as a disabled individual as long as the Title II disability benefits are received. MEM Proc. 22C-9

Important: Because the criteria for resubmitted cases differ from initial referrals, the type of referral must be correctly indicated on the MC 221.

A. Worker Initiated Reexamination

Thirty days prior to the reexamination date the worker should receive a tickler on the MER to submit a reexamination referral to DDSD. The worker will:

1) Obtain a new form MC 223 which includes the beneficiary's current physical and/or mental conditions as well as the beneficiary's current medical provider information and daily activities. A photocopy of the old form MC 223 is not acceptable.

2) Obtain a medical release form MC 220 for each medical provider or agency listed on form MC 223, plus three additional signed and dated MC 220s.

3) Complete form MC 221 marking "reexamination" as type of referral and entering the date form SAWS1 was signed, not the reexamination date. State the reason for the reexamination in the Comments Section.

4) Attach a photocopy of the prior form MC 221 or note the date of the prior decision on the new form MC 221. ACWDL 96-35

5) Attach any medical records or reports presented by the beneficiary since the last referral.

6) Send the completed packet to DDSD.

If the beneficiary does not respond or refuses to cooperate, the worker will first determine whether the individual is eligible for Medi-Cal under a different linkage factor. If not, the worker will take necessary actions to discontinue the case, and notify SP-DDSD of the action taken in these situations by completing the MC 222 and annotate in item number 9: "Client discontinued for failure to cooperate with Disability Reexamination." If a beneficiary cooperates, he/she continues to be considered disabled, and remains eligible for Medi-Cal until DDSD completes the reevaluation. ACWDL 96-35

B. Listings of MNO Disability Reexamination Cases Issued by SP-DDSD

Effective September 1996, the State Programs-Disability and Adult Programs Division (SP-DDSD) will establish a new procedure to follow up on all Medically Needy Only (MNO)-disabled cases (exceptions occasionally occur when SP-DDSD adopts a disability determination from a federal case and they cannot obtain the medical reexamination date):

1) Monthly Listing

SP-DDSD will generate and send to the Department of Health Services (DHS) monthly listings of active MNO-Disabled cases in which the medical reexamination has become due. DHS will in turn forward to the County DDSD liaison a copy of the list. ACWDL 02-18

Upon receipt of the listing from SP-DDSD, the DDSD liaison will send a gram to the supervisor of the worker assigned the case to inform of the reexamination referral that is due. ACWDL 02-18

Upon receipt of the informing gram from the DDSD liaison, the worker is required to submit a full disability packet (see Item 10A.) on each reexamination case within 90 days from the list date if a reexamination packet has not recently been sent. The worker will take necessary steps to assist the client in completing the necessary forms.

If the beneficiary does not respond or refuses to cooperate, the worker will first determine whether the individual is eligible for Medi-Cal under a different linkage factor. If not, the worker will take necessary actions to discontinue the case, and notify SP-DDSD of the action taken in these situations by completing the MC 222 and annotate in item number 9: "Client discontinued for failure to cooperate with Disability Reexamination-Delete name from Follow-Up list." ACWDL 96-35

2) 90 Days Follow Up ACWDL 02-18

If within 90 days from the list date, the worker does not forward disability packets on each of the listed individuals (or otherwise notify SP-DDSD of the reason why a disability packet is not forthcoming), SP-DDSD will generate a follow up list of the outstanding cases. This list will be sent to DHS, who will forward a copy of the list to the DDSD liaison. Again, the DDSD liaison will inform unit supervisors of the 90 days overdue referrals using the same procedure in 10B.1 above and the worker responsible for the case must take action to initiate the overdue disability reexamination packet.

If a disability packet for a case on a reexamination list is not submitted to SP-DDSD within 90 days, it will appear on a follow-up list. When this happens, the worker must submit the disability packet to SP-DDSD within 45 days of the date of the follow-up list. If the worker is unable to submit the packet within 45 days of the list date:

- the DDSD liaison must submit a copy of the list to DHS within 45 days of the list date, annotating on the list the reason the disability packet was not sent, or
- if a packet was sent late, the DDSD liaison is to indicate on the past due list the date the packet was sent to SP-DDSD and any action taken on the case.

All annotated past due case lists shall be sent to the DHS at 714 P Street, Room 1692, Sacramento, CA 94234-7320, Attention: Mr. Terry Durham.

C. Worker Action When Disability is Determined by SSA

If SP-DDSD initially determined the client disabled, a subsequent SSA Title II disability claim is **allowed**, and a reexam is due, SP-DDSD will adopt the federal reexam date as long as it is set at a future date or it is not pending. SP-DDSD will advise the worker that the federal case takes precedence and SSA's determination will be used to establish disability linkage. MEM Proc. 22C-9

If SP-DDSD initially determined the client disabled, a subsequent SSA Title II disability claim is **pending**, and a reexam is due, SP-DDSD will adopt the results of the federal reexam and advise the worker to verify disability status with SSA in 60 to 90 days. The worker will submit form 07-94 DSS, to SSA, 60 days after the reexamination date to request reverification of disability. Medi-Cal benefits will continue while the federal reexam is pending.

If SP-DDSD initially determined the client disabled, a subsequent SSA Title II disability claim is **disallowed**, and a reexam is due, the following procedures will be followed:

1) Federal Appeal Rights Exhausted

- If the beneficiary has exhausted all federal appeal rights, the federal disability decision was 12 or more months prior to SP-DDSD's reexam date and the final disability decision determined the beneficiary to be not disabled, the worker will evaluate for any other linkage. If no other linkage exists, the case must be discontinued and no referral will be made to SP-DDSD.

- If the beneficiary has exhausted all federal appeal rights, the federal decision was for non-disability reasons (e.g., over income limits, failure to cooperate or client's whereabouts are unknown, etc.), the case will be referred to SP-DDSD as a reexam.

2) Timely Appeal Filed

If the beneficiary was receiving Medi-Cal based upon disability and is later determined by SSA not to be disabled, and the beneficiary is not Medi-Cal eligible under any other basis, the beneficiary is entitled to receive continued Medi-Cal eligibility if he/she files a timely appeal of the SSA disability determination. **Medi-Cal benefits will continue while the SSA appeal is pending and until a final determination is made.**

If the beneficiary has filed a timely appeal of the federal disability decision and the SSA appeal is still pending, SP-DDSD will not complete a reexam on these cases. SP-DDSD will reset the reexam date according to the level at which the SSA appeal is pending which may vary from ninety days to two years. SP-DDSD will advise the worker, "An appeal is pending on a federal Title II/SSI denial/cessation. The case remains under SSA jurisdiction. A revised reexam date has been set for _____. At that time, SP-DDSD will determine whether a medical reexam is necessary."

D. Worker Action When Disability Status Changes

If an individual determined to be disabled at the time of the Medi-Cal application is later denied by SSA for either SSI/SSP or Title II disability benefits due to lack of disability, the worker must make a referral to DDSD for a reexamination. If DDSD determines that the beneficiary is no longer disabled, the beneficiary should be discontinued unless other linkage exists.

DDSD has requested that cases submitted for reexamination or reevaluation due to possible change in disability status be identified. Therefore, when submitting these types of packets, the worker must mark the type of referral on form MC 221 as "Reexamination" or "Reevaluation due to possible status change" and state the reason for the possible change in box 10 "County Worker Comments." This will ensure that proper DDSD procedures are followed without undue loss of time.

E. Worker Action When SP-DDSD Determines the Individual is No Longer Disabled

MEM Proc. 22C-9

If SP-DDSD determines that the individual is no longer disabled, SP-DDSD will return the MC 221 with the "No Longer Disabled" determination attached. The worker will determine if any other linkage exists. If no other linkage can be established, the worker will issue a timely discontinuance notice that he/she is no longer considered disabled and that the Medi-Cal benefits will be discontinued.

12. REEVALUATIONS

The worker may request a new evaluation of disability, **within 90 days** of SP-DDSD's decision, when the worker disagrees with the decision rendered by DDSD or believes the evaluation results may not be correct. A complete disability packet is required for most reevaluations. However, a limited DDSD packet is acceptable when there are no new treatment sources alleged and the packet is sent within 30 days of SP-DDSD's decision or an earlier onset date on an approved case is needed. Both the complete and limited DDSD packets must include a detailed explanation, in the comments section of the MC 221, of the reason for the disagreement. Requests for reevaluation should not be made unless the worker has reason to believe that one of the following circumstances exists:

A. SP-DDSD has performed an independent disability evaluation and denied the claim. The applicant states:

1) His/her condition has deteriorated since the DDSD denial;

2) New medical evidence not considered by DDSD is available;

3) A new physical and/or mental impairment not previously reported now exists; or

B. The worker has reason to believe that when the claim was denied, DDSD was unaware of certain medical evidence, conditions, or recent occurrences which could change the outcome of the decision.

Example: The applicant alleges disability due to heart disease. DDSD denies disability and so informs the worker on form MC 221. The worker is preparing the denial notice when the applicant's spouse informs the worker that the applicant has been hospitalized due to a myocardial infraction. The worker may request a reevaluation due to the applicant's severe change in condition.

C. DDSD adopted a SSA denial, and the applicant has a totally new physical or mental condition, which the worker believes would make the SSA decision obsolete and the client has decided not to appeal SSA's decision. Refer this claim to DDSD.
Example: A claim was denied by SSA because the client's leg problem was not disabling. The client learns that he/she also has cancer and does not appeal the federal denial. The worker may refer the claim to SP-DDSD.

D. DDSD adopted SSA's denial and within 12 months of the denial the client claims a worsening of the same condition, which was evaluated by SSA, or has obtained new medical evidence regarding the same condition that SSA did not consider in its previous evaluation. If either situation occurs within 12 months of SSA's denial, the client should be instructed to file an appeal. If either situation occurs after 12 months of SSA's denial and the client has not reapplied, a new DDSD packet will be required.

13. REDETERMINATION

A redetermination of a person's disability status will be requested for an applicant who meets certain criteria:

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A. Criteria

1) Was previously determined disabled by SP-DDSD; and

2) Was discontinued for a reason other than disability; and

3) Reapplies for Medi-Cal alleging that the same disability continues to exist.

B. Type of Packet

A **limited** DDSD packet **must** be sent in all redetermination packets unless the following circumstances exist, which require a **complete** DDSD packet:

1) The reapplication date is more than 12 months since the person was discontinued from Medi-Cal; or

2) No reexam date was set on the previous MC 221; or

3) The reexam date is unknown, due or past due; or

4) An improvement in the person's condition is noticed.

A copy of the prior MC 221 must be included with both the limited and the complete DDSD packets. Check the Redetermination box on the new MC 221 and provide an explanation in the Comments section.

Unless other linkage exists, the case will be placed in **pending** status and Medi-Cal benefits will not be granted until SP-DDSD returns its determination.

DDSD will check with SSA to determine if there has been a subsequent federal determination within the past 12 months. If there has been a federal denial/cessation of benefits, DDSD will adopt the SSA decision and the person will be referred back to SSA. The Medi-Cal application will be denied.

14. SPECIAL SITUATIONS

A. Death

DDSD will automatically grant disability status for a person for the month of death. Although disability status is automatic only for the month of death, the State will consider requests for a retroactive onset. If a retroactive onset appears appropriate (i.e., the applicant was hospitalized in the month prior to death), the retro onset box must be checked.

If request for coverage is for the month of death only, note "No earlier onset needed" in Section 10 of form MC 221.

If an applicant dies after a DDSD referral has been initiated the worker should notify DDSD of the applicant's death by phone and follow up with form MC 222. This information will help expedite the determination.

NOTE: Although death is considered disability status, the worker cannot grant Medi-Cal presumptively. The purpose of granting Medi-Cal presumptively is to expedite issuance of a Medi-Cal card so that a patient who meets presumptive criteria can receive medical treatment right away. A deceased person does not fit that situation.

A death certificate expedites processing, but it is not required. DDSD will either contact the family or will obtain the certificate through government records if one is not provided.

B. Disabled Children

If the applicant indicates that there is a disabled or potentially disabled child in the home, the applicant will complete form MC 223 and indicate his/her relationship to the child on the form. The DDSD packet will be processed in the normal manner.

C. Railroad Retirement Board (RRB) Disability Verification

1) Disability Criteria

State regulations require that disability for Medi-Cal purposes be determined using Title II disability or SSI/SSP criteria. RRB is the federal agency responsible for administering the retirement system for railroad employees. RRB issues two types of disability benefits:

a) Total and Permanent Disability

RRB evaluates total and permanent disability using Title II/SSI/SSP disability criteria. A retired railroad employee who meets this criteria therefore meets the disability criteria for Medi-Cal.

b) Occupational Disability

RRB occupational disability is established by a determination that the individual cannot perform his/her last railroad job. Title II/SSI/SSP criteria are not used to make the determination. Further, occupational disability does not consider whether the individual is capable of performing other past work (including previous railroad jobs) or other work existing in significant numbers in the national economy. Benefits issued because of an occupational disability do not establish disability for Medi-Cal purposes.

2) Verification Procedures

The worker will:

a) Request the applicant to submit verification of RRB disability benefits which identifies the type of benefit awarded. The applicant may use an RRB award notification or if none is available, the applicant has the responsibility to obtain a written statement from RRB identifying the type of disability benefits awarded. The worker may help the applicant by sending a written request to the RRB district office having jurisdiction over the applicant's RRB case.

b) Deny the application for failure to cooperate if the applicant/beneficiary fails or refuses, without good cause, to cooperate in obtaining the information. If the applicant/beneficiary states he/she knows that the award basis is occupational disability and does not wish to go through verification for that reason, do not deny the application for failure to cooperate. (See Item 13.D.3).

If a beneficiary's request for reclassification as a disabled person is denied for failure to cooperate, only the reclassification is affected. DO NOT DISCONTINUE MEDI-CAL BENEFITS UNLESS ALL OTHER LINKAGE CEASES OR ANOTHER REASON FOR DISCONTINUANCE EXISTS.

3) Worker Action

a) If RRB benefits were issued on the basis of total and permanent disability, the applicant is disabled for Medi-Cal. The worker will:

(1) Document on form JA2 or MC 210 the disability onset (or date benefits began if prior to Medi-Cal effective date), type of RRB disability award, and date of the RRB notice; and

(2) Evaluate the other Medi-Cal eligibility criteria.

b) If RRB benefits were issued based on occupational disability, the applicant is not disabled for Medi-Cal purposes. The worker must submit a complete referral to DDSD.

D. Federal Decisions

The county will rescind a prior Medi-Cal denial, after following the 1990 Regulations which require that a Medi-Cal application be denied and the client referred back to SSA. MEM Proc 22C

1) If SSA approves disability after originally denying the claim, the worker will rescind the prior Medi-Cal denial and approve Medi-Cal, if otherwise eligible. A new application or referral to DDSD is not needed if SSA's disability onset date coincides with the request for Medi-Cal.

2) If retro Medi-Cal is needed, a full referral packet will be sent to DDSD. Include a copy of the SSA award letter. In Item 5 of the MC 221, indicate initial Medi-Cal application date (before client was referred to SSA) to protect client's original filing date and specify "client was originally denied and referred to SSA for reopening" in Item 10 (comments section) of the MC 221.

NOTE: Request for retro onset must be made within one year of the month for which retroactive coverage is requested. MEM Proc 22C

E. Subsequent SSA Disability Denial ACWDL 87-54 and SDHS Letter dated 10/6/95

When the State DDSD has determined that an applicant is disabled and the applicant becomes a Medi-Cal beneficiary and a subsequent SSA disability denial determination becomes available, workers will not discontinue Medi-Cal benefits at that time due to the Disabled Rights Union (DRU) lawsuit.

In February 1987, a restraining order was issued in the case of the (DRU) vs. Kizer preventing the termination of Medi-Cal for individuals subsequently denied SSA disability benefits. This court order is still in effect.

If the worker becomes aware that a beneficiary was denied disability on his/her SSA claim, the worker will flag the case by entering a "J" code in the L-Line Special Characteristic Box E. This is so that it can be identified in future when these cases will finally be terminated from Medi-Cal. The worker will not re-refer the case back to State DDSD for a reevaluation or reexamination.

15. RECEIVING AND REQUESTING DDSD STATUS INFORMATION

A. Quarterly Computer Status List

The Mission Valley District Office DDSD Liaison will receive a quarterly computer status list from DDSD regarding pending and closed disability cases, along with instructions on

its use. If a particular case was forwarded to DDSD prior to the most recent quarterly list and does not appear on list, the liaison may contact DDSD Operations Support Unit Supervisors by telephone or in writing to obtain status information, as follows:

Los Angeles State Programs, Branch

Myra Ancla
Operations Support Analyst
CDSS – DDSD – LASPB
P.O. Box 30541 Terminal Annex
Los Angeles, CA 90030
Phone: (213) 480-6453
Fax: (213) 480-6309

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If status is required on several applications, a list of case names/Social Security numbers should be faxed to the Operations Support Analyst. Complex DDSD issues and all Presumptive Disability (PD) requests should also be referred to the Operations Analyst. Inquiries may be made via phone or fax. PD requests must be faxed.

ACWDL 02-47

B. Questions and Inquiries on Specific Cases

All inquiries are to be handled by the Mission Valley DDSD Liaison. Only in urgent or unusual circumstances (i.e., there is a need for major emergency medical care and it is necessary to expedite the case/referral disposition), questions and inquiries about specific cases may be directed to the Disability Evaluation Analyst (DEA) assigned to the case, or the Unit Manager. **Under no circumstances should workers reveal the physical location of SP-DDSD to the Medi-Cal applicant/beneficiary**. If there is a need for the DEA to contact the applicant during the disability evaluation process, it is by telephone or in writing to the P. O. Box address.

To determine which DEA or Unit is assigned to the case or for routine status inquiries, provide the client's name and Social Security number to Masterfiles, at the following number:

Los Angeles State Programs Branch

Master files: (213) 480-6400
8-677-6400 CALNET

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Proc. 22C-7

C. Problems With Case Status Information, Referrals or Delayed Decisions

Problems with obtaining case status information, which cannot be resolved with DDSD, will be referred to Policy & Program Development Division (P&PDD). P&PDD will contact the State Department of Health Services to help resolve the problem.

"WHAT YOU SHOULD KNOW ABOUT YOUR MEDI-CAL DISABILITY APPLICATION"
MC 017

STATE OF CALIFORNIA – HEALTH AND WELFARE AGENCY DEPARTMENT OF HEALTH SERVICES

WHAT YOU SHOULD KNOW ABOUT

YOUR MEDI-CAL DISABILITY APPLICATION

SHOULD YOU APPLY FOR MEDI-CAL DISABILITY?

You should apply if you have a physical or mental condition that makes you unable to work for at least 12 months in a row.

Have you applied for and been denied Social Security disability or SSI in the past 12 months? If you have, you must tell your Eligibility Worker.

WHAT HAPPENS AFTER YOU HAVE APPLIED?

Usually, your disability claim will be sent to the Disability Evaluation Division (DED) of the State Department of Social Services. A disability analyst and a medical doctor will evaluate it. Your Eligibility Worker does not have the authority to decide disability.

- After the DED office receives your disability claim, they may contact you to get more information. If you get a letter, do what the letter says. Keep the letter and call the analyst named in the letter if you have questions about your disability claim.
- The DED office may contact you to arrange for a special medical exam. If you are asked to go to an exam, the exam is free to you and will be used to decide if you are disabled. Do not miss or cancel the exam.
- If you receive letters or phone calls from your disability analyst, answer right away.
- Tell your doctor(s) they may be contacted and that it will help if they send the requested information quickly.
- It is important that you quickly report any changes, especially in address or telephone number to your county Eligibility Worker. Your worker will send this information to the disability analyst. If you are homeless, be sure to keep in touch with your Eligibility Worker.
- Give your worker the phone number and address of a family member, friend, or other person who your worker can contact if you can't be reached.
- If it is decided that you are disabled, your county Eligibility Worker will contact you to get current information on your financial situation. **IT IS IMPORTANT THAT YOU PROVIDE THIS INFORMATION.**

MC 017 (10/93)

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22C

SSA CLIENT REFERRAL CHART
DDSD

Items 5 to 5D of the MC223, Applicant's Supplemental Statement of Facts For Medi-Cal identify whether client has applied for Social Security or SSI disability benefits in the past two years. Client's responses determine whether a disability claim is referred to SSA or DDSD. The following chart helps to identify if a DDSD packet should be submitted or the client referred to SSA.

CLIENT SSA STATUS	SITUATION	QUESTIONS AND ANSWERS	REFER CLIENT TO SSA	SUBMIT PACKET TO DDSD
1. Did Not Apply		Q 5 = No		X
2. Applied	Application Status Unknown or Pending	Q 5 = Yes Q 5A = Unknown/Pending		X
3. Allowed/Denied	Decision On Appeal	Q 5 = Yes Q 5A = On Appeal	X	
4. Allowed	Has SSA award letter proving current receipt of benefits.	Q 5A = Approved	None	None
5. Allowed	Has SSA award letter proving current receipt of benefits. Needs retro Medi-Cal.	Q 5A = Approved		X
6. Denied	Has SSA letter proving denial based on income and/or resources.	Q 5A = Denied		X
7. Denied	Denial within previous 60 days. Did not ask SSA to reconsider the previous denial.	Q 5B = Date within 60 days	X	
8. Denied	Denial within 12 months. Alleges worsening of same condition. (Provides proof, if condition now meets Presumptive Disability criteria.) Did not ask SSA to reopen previous denial.	Q 5B = Date within 12 months Q 5C = Yes	X	
9. Denied	Denial within 12 months. Has SSA letter proving SSA refusal to reopen previous denial.	Q 5B = Date within 12 months		X
10. Denied	Denial within 12 months. Alleges new condition not considered by SSA. Has not reapplied with SSA.	Q 5B = Date within 12 months Q 5D = Yes		X
11. Denied	Denial within 12 months. Does not allege new condition or worsening of the same condition.	Q 5B = Date within 12 months Q 5C/D = No	X	
12. Denied	Denial over 12 months. Same condition worsened, or has new medical problem not considered by SSA. Has not reapplied or appealed with SSA.	Q 5B = Date over 12 months Q 5C/D = Yes		X
13. Denied	Denial over 12 months. No worsening of same condition, or has no new medical problems.	Q 5B = Date over 12 months Q 5C/D = No	X	

If the client is referred to SSA, the worker will deny the disability application using negative action code 107. This negative code will trigger the MC 239 SD NOA and the MC Informational Notice 13 — Important Information Regarding Your Appeal Rights, Social Security Information.

NOTE: See 5-4-13D, when client is referred back to SSA and SSA approves the disability after originally denying the claim.

DAPD/90 DAY STATUS LETTER
AL 738/MC 179

STATE OF CALIFORNIA – HEALTH AND WELFARE AGENCY
MEDI-CAL PROGRAM

DEPARTMENT OF HEALTH SERVICES

(County Address)

Date: _____
Case Name: _____
Case No.: _____
Worker Name: _____
District: _____

This letter is to tell you that all of the information necessary to refer your case to State Programs, Disability Evaluation Division for a disability determination has not been received.

Though federal law requires that eligibility for Medi-Cal based on disability be decided within 90 days, we are not able to do so in your case due to the reason(s) checked below.

We are awaiting the following information:

- ☐ For you to respond to our request for additional information (_____)
- ☐ For you to respond to our request to come into the office
- ☐ For you to contact your eligibility worker RIGHT AWAY because
  your disability form(s) is not completed correctly
- ☐ Other _____
  _____
  _____

If you have questions about your Medi-Cal application, call me at ( ) ___ between _____ a.m. and _____ p.m.

MC 179 (4/93)

State of California – Health and Human Services Agency | Department of Health Services

Name of disabled person	Social security number

SGA WORK SHEET

(Used when gross earned* income is over the current SGA amount.)

1. Earned Income
   a. Gross average monthly earnings $_____
   b. Payment in kind (e.g., room and board) which is ***not*** a condition of employment (use current market value) _____
   c. Other _____
   d. **TOTAL GROSS EARNINGS** (add a, b, and c) $_____

2. Impairment-Related Work Expenses (IRWEs)
   (see MEPM, Article 22, 22C-2)
   a. Attendant care services $_____
   b. Transportation costs _____
   c. Medical devices _____
   d. Work-related equipment _____
   e. Prosthesis _____
   f. Residential modifications _____
   g. Routine drugs and routine medical services _____
   h. Diagnostic procedures _____
   i. Nonmedical applications and devices _____
   j. Assistants (e.g., if visually impaired, cost to hire reader) _____
   k. Other items and services _____

3. **TOTAL IRWEs**: Add (total of 2a through 2k) $_____

4. **TOTAL SUBSIDY** (e.g., some employers employ disabled persons and subsidize their wages by paying them the same wages as a nondisabled employee though they may be performing less strenuous work, or working less hours) (from MC 273, number 7) $_____

5. **NET COUNTABLE EARNINGS** (subtract 3 and 4 from 1d) $_____

   - Are current countable earnings greater than $_____? ❒ Yes ❒ No
     (Insert current SGA amount)
   - If the answer is No, send a disability referral to SP-DAPD. In item 10 of the MC 221, Disability Determination and Transmittal, write in "No SGA issue." Attach copy of MC 272 to the MC 221.
   - If the answer is Yes, the client is engaging in SGA. Deny the disability claim. (Evaluate client for the Working Disabled Program.)

***NOTE:** Income information obtained from completed MC 273 (Work Activity Report).

Eligibility Worker signature	Worker number	Date completed

MC 272 (8/01)

State of California – Health and Human Services Agency

Department of Health Services

WORK ACTIVITY REPORT

This report is for:	
Month	**Year**

You may be considered disabled for Medi-Cal if you cannot do any kind of work for which you are suited, and only if you cannot work for at least a year or your condition will result in death.

If your gross earnings are more than $_____ (*current SGA amount*) per month, you might not be considered disabled. Work expenses and special work considerations related to your disability may be deducted in figuring whether your earnings meet the earnings limit. For this reason, information about your work activity is needed.

The information you provide about your work activity will be used in making a decision on your case. Your employer may be contacted to verify the information you provide.

Name of disabled person			Social security number	
Employer's name			Employer's telephone number ( )	
Employer's address (number, street)	City		State	ZIP Code
Title or name of your job	Rate of pay	Hours worked per week	Dates worked (month/year) From:_____ To:_____	
Employer's name			Employer's telephone number ( )	
Employer's address (number, street)	City		State	ZIP Code
Title or name of your job	Rate of pay	Hours worked per week	Dates worked (month/year) From:_____ To:_____	

1. **Gross Earning -** What is your gross monthly pay? (If pay is irregular, you do not need to enter the amount.) Attach your pay stubs.

2. **Other Payments -** Specify other payments you receive, such as tips, free meals, room or utilities. Indicate what you were given and estimate the dollar value and how frequently you receive them.

3. **Special Employment Situations**

	Yes	No
After you became ill, did your job duties lessen?	❒	❒
If yes, did you get to keep your same pay?	❒	❒
Are you employed by a friend or relative?	❒	❒
Are you in a special training or rehabilitation program?	❒	❒

4. **Job Requirements -** Are your job duties listed below different from those of other workers with the same job title?

	Yes	No
a. Shorter hours	❒	❒
b. Different pay scale	❒	❒
c. Less or easier duties	❒	❒
d. Extra help given	❒	❒
e. Lower production	❒	❒
f. Lower quality	❒	❒
g. Other differences (e.g., frequent absences)	❒	❒

5. **Explanation of Job Requirements -** Describe all "yes" answers in item 4 on page 1.

6. **Special Work Expenses -** Specify below any special expenses related to your condition which are necessary for you to work. These are things which you paid for and not things that will be paid for by anyone else.
Specify the amount of the expenses. Attach verification of who prescribed the item or service needed and the cost paid. (We are required to verify the need for the item or service with the person who prescribed it.)

   Example: Attendant care services, transportation costs, medical devices, work-related equipment, prosthesis, modifications to your home, routine drugs and medical services necessary to control a disabling condition, diagnostic procedures, assistants (e.g., if visually impaired, the cost to hire a reader; if hearing impaired, the cost to hire a sign language interpreter), or similar items or services.

   _____
   _____

7. **Subsidies -** Some employers will support disabled individuals with subsidies. For example, the employer may subsidize the disabled employee's earnings by paying more in wages than the reasonable value of the actual work that was done. (For example, many sheltered work centers subsidize an individual's earnings.)

   Does your employer provide you with subsidies? ❒ Yes ❒ No

   If yes, please (a) tell us how much the subsidy is worth and (b) explain the type of subsidy that was given.

   a. $_____

   b. Explanation of subsidy:_____
   _____
   _____

8. Use this additional space to answer any previous questions or to give additional information that you think will be helpful.

   _____
   _____
   _____
   _____

9. Please read the following statement. Sign and date the form. Provide address and telephone number.

   If my employer should need to be contacted, this also authorizes my employer to disclose any information necessary for the county to evaluate my work activity for my Medi-Cal application based on disability.

   I have completed this form correctly and truthfully to the best of my knowledge and abilities.

Signature of applicant or representative	Date	Area code and telephone number ( )

Mailing address (number, street, apartment number, P.O. box number, or Rural Route)

City	County	State	ZIP code

CHECKLIST FOR COUNTY USE ONLY

1. Enter amount of client's gross wages. $_____
   Does the client have any of the following deductions?

   a. Subsidy (see MEPM, Article 22, 22C-2.7) ❒ Yes ❒ No If yes, enter amount: $_____
   b. Impairment-related work expenses (IRWEs) ❒ Yes ❒ No If yes, enter amount: $_____

2. Add a and b above and subtract total from number 1. Is the remainder over the current SGA amount?
   If yes, client is engaging in SGA. If any explanations are needed, please use the following space:

_____
_____
_____

Eligibility Worker Signature	Worker number	Date completed

AUTHORIZATION FOR RELEASE OF INFORMATION
MC 220

State of California—Health and Human Services Agency

Department of Health Services

AUTHORIZATION FOR RELEASE OF INFORMATION

Whose records are to be disclosed:		
Name—First	Middle	Last
Social security number	Date of birth (mm/dd/yyyy)	

PLEASE READ THE ENTIRE FORM, BOTH PAGES, BEFORE SIGNING.

I voluntarily authorize and request disclosure (including paper, oral, and electronic interchange):

OF WHAT: All my medical records; also education records and other information related to my ability to perform tasks. This includes specific permission to release:

1. All records and other information regarding my treatment, hospitalization, and outpatient care for my impairment(s) including, and not limited to:
   - Psychological, psychiatric, or other mental impairment(s) (excludes "psychotherapy notes" as defined in 45 CFR 164.501)
   - Drug abuse, alcoholism, or other substance abuse
   - Sickle cell anemia
   - Human immunodeficiency virus (HIV) infection (including acquired immunodeficiency syndrome [AIDS] or tests for HIV) or sexually transmitted diseases
   - Genetic test results
2. Information about how my impairment(s) affects my ability to complete tasks and activities of daily living or affects my ability to work.
3. Copies of educational tests or evaluations, including Individualized Educational Programs, triennial assessments, psychological or speech evaluations, and any other records that can help evaluate function; also teacher's observations and evaluations.
4. Not only past information, but also information created within 12 months after the date this authorization is signed.

FROM WHOM:
- All medical sources (hospitals, clinics, physicians, psychologists, labs, etc.) including mental health facilities
- All educational sources (schools, teachers, records administrators, counselors, etc.)
- Social workers/rehabilitation counselors
- Consulting examiners used by State Programs–Disability and Adult Programs Division (SP–DAPD)
- Employers
- Others who may know about my condition (family, neighbors, friends)

TO WHOM: The California State Department of Social Services (CDSS) or the State Department of Health Services (SDHS) for the purpose of determining whether I qualify for disability benefits, including contract copy services used to duplicate the records, and doctors or other professionals consulted during the process of making the determination.

PURPOSE: Determining my eligibility for benefits, including looking at the combined effect of any impairments that by themselves would not meet the Social Security Administration's definition of disability.

EXPIRES WHEN: This authorization is good for 12 months from the date signed.
- I authorize the use of a copy (including electronic copy or fax) of this form for the disclosure of the information described above.
- I understand that there are some circumstances where this information may be redisclosed to other parties (see page 2 for details).
- Except for actions already taken, I may write to the Disability and Adult Programs Division and my sources to revoke this authorization at any time (see page 2 for details).
- I am entitled to a copy of this form, if I ask; I also have a right to ask the source to let me inspect or get a copy of the material to be disclosed.
- **I have read both pages of this form and agree to the disclosure above from the types of sources listed.**

INDIVIDUAL authorizing disclosure

Signature ➤	Date	MINOR CONSENT SERVICES ONLY ☐ Yes ☐ No

If not signed by subject of disclosure, specify basis for authority to sign

☐ Parent of minor ☐ Guardian ☐ Other personal representative (explain relationship to subject and why the subject is unable to sign.)

NOTE: MINORS AGE 12 AND OLDER WHO COULD CONSENT TO SERVICES UNDER THE FAMILY CODE, MUST SIGN A RELEASE. ADDITIONALLY, THE PARENT OR GUARDIAN OF EVERY MINOR MUST SIGN A SEPARATE RELEASE EXCEPT IN THOSE CASES INVOLVING MINOR CONSENT ONLY. (See explanation on the reverse.)

WITNESS: I know the person signing this form or am satisfied of this person's identity: (Required for "X," illegible, or foreign character signatures)

Signature ➤		Date	
Street address (number, street)	City	State	ZIP code

This general and special authorization to disclose information has been developed to comply with the provisions regarding disclosure of medical and other information under: The Health Insurance Portability and Accountability Act, Section 262 (a), 42 U.S. Code, Section1320d–1320d-8 (45 CFR Part 164); 42 U.S. Code, Section 290dd-2 (42 CFR part 2); 38 U.S. Code, Section 7332; 20 U.S. Code, Section 1232g (34 CFR Parts 99 and 300); and state law, including Civil Code, Section 56.10(b), Welfare and Institutions Code, Sections 10850 and 14100.2 and Civil Code, Sections 1798–1798.78.

DO NOT ALTER THIS FORM

MC 220 (4/03)

Page 1 of 2

Explanation of MC 220
AUTHORIZATION FOR RELEASE OF INFORMATION

We need your written authorization to help you get the information required to process your application for disability. Laws and regulations require that sources have an authorization before releasing information to us. Also, laws require authorization for the release of information about certain conditions and from educational sources.

You can provide this authorization by signing a form MC 220. Federal law permits sources with information about you to release that information if you sign a single authorization to release all your information from all your possible sources. If you sign such a single authorization, we will make copies of it for each source we contact to get your information. If for any reason we need additional authorizations, we will contact you.

The reason we need minors age 12 and older to sign an authorization, in addition to the authorization signed by the parent/ guardian, is that a confidential physician-patient relationship can exist between a child and his/her doctor based on Family Code, Sections 6920–6929 under certain circumstances once the child turns 12 years of age. HIPAA authorizes disclosure in reliance on the authorization of an unemancipated minor when other provision of law allows the minor to authorize the treatment or care described in the documents to be disclosed. [45 CFR § 164.502(g)(3).] Consequently, it may be necessary to secure the child's consent in lieu of or in addition to consent by a parent in order to secure access to the needed information.

You have the right to revoke and/or modify this authorization at any time, except to the extent an action has already occurred. To do so, send a written statement to State Programs-Disability and Adult Programs Division, Attention: Professional Relations Specialist. If you do, also send a copy directly to any of your sources of information that you no longer wish to disclose information about you. The California Department of Social Services can tell you if we identified any sources you did not originally tell us about. As described below, revocation or modification could result in loss of benefits.

IMPORTANT INFORMATION, INCLUDING NOTICE REQUIRED BY THE INFORMATION PRACTICES ACT

All personal information collected by CDSS is protected by the Information Practices Act of 1977. In addition, information made or kept by CDSS or the SDHS in connection with the Medi-Cal program is protected by California Welfare & Institutions Code, Section 14100.2; and Title 42, United States Code (USC), Section 1396a(a)(7). Information is retained by CDSS in adherence to retention schedules prescribed by the department.

CDSS is authorized to collect the information, acting under an agreement with the SDHS, on this form under Section 14011 of the California Welfare and Institutions Code and regulations in Title 22, California Code of Regulations (CCR). The information on this form is needed to make a decision on the named applicant or beneficiary's application for, or continued eligibility for, Medi-Cal based on disability. While giving us the information on this form is voluntary, failure to provide all or part of the requested information could prevent an accurate or timely decision on the named applicant's application or on the continuation of benefits. Although the information obtained with this form is not typically used for any purpose other than making a determination of the applicant's disability status, such information may be disclosed by CDSS or SDHS for reasons related to the administration of the Medi-Cal Program, such as, but not necessarily limited to: (1) to enable a third party or agency to assist CDSS or SDHS in establishing rights to Medi-Cal benefits, (2) to facilitate statistical research, audit activities and fraud and abuse investigations/programs necessary to assure the integrity and improvement of the Medi-Cal Program, and (3) in administrative and related legal proceedings involving your appeal of a decision of the Medi-Cal Program. An individual has a right to access records containing his/her personal information that are maintained by CDSS. The official responsible for maintaining the information is the Deputy Director of the Disability and Adult Programs Division, 744 P Street, Sacramento, CA 95814, (916) 657-2265.

ATTENTION APPLICANTS/RECIPIENTS FOR CASH ASSISTANCE PROGRAM FOR AGED, BLIND OR DISABLED IMMIGRANTS (CAPI)

In CAPI cases, in addition to the protection afforded to personal records by the Information Practices Act, as discussed above, the documents and information collected based on this authorization are subject to the protection accorded by Welfare and Institutions Code, Section 10850, et. seq., but not that provided by Welfare and Institutions Code, Section 14100.2 or other provisions applicable to the Medi-Cal Program. In general, Section 10850 forbids disclosure of lists of recipients on nonmedical public social services such as CAPI, or other identifying information or personal information for any purpose not connected with the administration of CAPI. The law authorizes the use of the records in connection with investigation, auditing, and in administrative, civil and criminal proceedings connected with CAPI program administration. The law also authorizes the sharing of such information with other public agencies for the purposes of determining eligibility for and other purposes connected with the administration of public social services, and with school officials for the purposes of administering federally assisted programs providing cash assistance or in-kind services directly to individuals based on need. Also, the law authorizes disclosure of information for research purposes, provided that information identifying the person who the records are about, is removed from the records. There is also the possibility of disclosure pursuant to an order of a court of competent jurisdiction. In reality, however, the kinds of records actually collected for the CAPI program based on this authorization are likely to be used exclusively for determining disability, except where a court orders disclosure for other purposes.

DISABILITY DETERMINATION AND TRANSMITTAL
MC 221

State of California – Health and Human Services Agency | Department of Health Services

PLEASE PRINT

County Welfare Department Address

Retain Copy 4
(Send copies 1, 2, and 3 to DAPD)
DO NOT MAIL TO APPLICANT

County number | Aid code | Case number

DAPD Address

Los Angeles State Programs Branch
P.O. Box 30541, Terminal Annex
Los Angeles, CA 90030

1. Applicant name (first) (middle name) (last)

2. Social Security number
☐ Pending ☐ None

3. Date of birth
Month Day Year

4. Sex ☐ Male ☐ Female

5. Date applied
Month Day Year

*6. List retro month(s)
___/___ ___/___ ___/___
Month Year Month Year Month Year

7. Mailing address

*8. Type of referral (check appropriate box(es))
☐ Initial referral ☐ IHSS ☐ Retro-onset
☐ Redetermination ☐ SGA IHSS ☐ Limited referral
☐ Reevaluation ☐ SGA-disabled ☐ Other-explain (item 10)
☐ Pickle-blind ☐ CAPI
☐ Reexamination ☐ Resubmitted packet

Telephone number: (area code)

9. Is applicant in a hospital? ☐ Yes ☐ No
Name of hospital:

10. County worker comment(s) (If more space is needed, attach a separate sheet.) ☐ See attached sheet (e.g., DHS 7045)

☐ (MC 179) 90-Day Status Letter attached ☐ Presumptive Disability approved

11. File reviewed and approved for transmittal

Worker number	Print worker name	
Telephone number (area code)	FAX number (area code)	12. Date sent Month Day Year

DAPD USE ONLY

13. ☐ See attached DAPD Documents (This is NOT a certification for in-home supportive services.)
Comment(s) or SP-DAPD Presumptive Disability decision

14. Analyst	15. Date
16. Team manager	17. Date

DISABILITY DETERMINATION AND TRANSMITTAL

SEE BACK OF COPY 4 ☐ Oakland ☐ Los Angeles

MC 221 LA (1/00)

Due to the fact that items 5, 6, and 8 are frequently misunderstood, the following explanations are given:

Item 5: Date applied: For a new Medi-Cal applicant, enter the date the SAWS 1 was signed. For a continuing case, enter the date that the disability was first reported to the county.

Item 6: List retro month(s): List all months for which applicant requests coverage during the retroactive period (not more than three months prior to any application date).

Item 8: Check all boxes that apply.

Initial Referral: Check this box to request first-time evaluation for disability or blindness. This is used for all initial referrals.

Redetermination: Check box if a beneficiary was previously determined to be disabled, was discontinued for a reason other than cessation of disability, AND (1) the last DAPD determination occurred 12 or more months in the past, OR (2) whose reexamination date is due/past due or unknown. Attach a copy of the prior MC 221.

Reevaluation: Check box if the county disagrees with DAPD's determination and is sending the case back for another review within 90 days of DAPD's decision. Reason for the disagreement must be explained in item 10. Attach a copy of the prior MC 221.

Pickle-Blind: Potentially blind individuals who are discontinued from SSI for any reason must be screened under the Pickle program (DHS 7020). Blindness evaluations for former SSI recipients for a determination under the Pickle Amendment to the Social Security Act may be necessary even if the individual has reached age 65 or has already been determined to be disabled. This is because blind individuals are entitled to a higher SSI payment level than disabled or aged persons.

Reexamination: Check box if a reexam date is due/past due or if an evaluation of a beneficiary's disability is needed to determine if medical improvement has occurred. Attach a copy of the prior MC 221.

IHSS: In Home Supportive Services. Check box if a disability evaluation is needed for an IHSS applicant.

SGA IHSS: Check box if an applicant's SSI benefits have been discontinued due to SGA and the applicant is in need of IHSS. In these DAPD evaluations, DAPD must confirm that the applicant's SSI benefit was discontinued due to SGA and prove that the impairment(s) for which SSI was allowed has not improved.

SGA Disabled: Substantial Gainful Activity (SGA). Check box if an applicant was an SSI disabled recipient, became ineligible for SSI because of SGA (gainful employment), and still has the medical impairment which was the basis of the SSI disability determination.

CAPI (Cash Assistance Program for Immigrants): This program provides cash assistance to aged, blind and disabled legal immigrants who meet the SSI immigration status requirements effective August 21, 1996, and all other current SSI eligibility requirements. If not aged (65 years of age or older), then disability/blindness must be established on an individual before CAPI payments can be made.

Resubmitted Packet: Check box if the original packet was received by DAPD and subsequently returned to the county for needed information, i.e., Z56 (no determination) or Z55 (county return for packet deficiency, upon resubmitting to DAPD, county should attach a copy of the SPB 105 letter which DAPD previously attached to the returned packet). The county will furnish the needed information and return the packet to DAPD as a Resubmitted Packet. Attach a copy of the prior MC 221.

Retro-Onset: Check box only if the beneficiary was previously determined to be disabled and the case is being resubmitted to evaluate for an earlier onset date. (Onset cannot be granted more than three months prior to application.) Attach a copy of the prior MC 221 to the packet. **For new referrals, *DO NOT* check this box; simply indicate the requested onset in item 6.**

Limited Referral: Appropriate under the following circumstances: (1) A reevaluation packet is sent back within 30 days of DAPD decision and no new treating source alleged; (2) an earlier onset is needed after DAPD approved case (no new treating sources are alleged during earlier onset period) and it is within 12 months of application; (3) client discontinued from SSI due to excess income/resource and not receiving Title II disability benefits; (4) application is made on behalf of deceased client and death certificate is included; or (5) county unable to verify SSI benefits and only verification for SSI benefits for IHSS is requested.

MC 221 (1/00)

SUPPLEMENTAL STATEMENT OF FACTS
MC 223

State of California – Health and Welfare Agency | Department of Health Services

APPLICANT'S SUPPLEMENTAL STATEMENT OF FACTS FOR MEDI-CAL

COUNTY USE ONLY
County Number/Aid Code/Case Number

PART I – PERSONAL INFORMATION

1a. Applicant name (Last, First, MI)	1b. Social Security number: — —	1c. Date of birth
1d. Other name(s) used (Last, First, MI)	1e. Sex ❒ Male ❒ Female / 1f. Height Feet_____ Inches_____	1g. Weight Pounds_____

2a. Home address	City	State	ZIP code
2b. Mailing address (if different)	City	State	ZIP code

3. Daytime telephone number	Check if ❒ No Phone ❒ Message Phone (_____) _____	Best time to call
4a. Do you speak English? ❒ Yes If YES, go to Part II ❒ No If NO, what language(s) do you speak: _____ _____	4b. Do you have an interpreter? ❒ Yes ❒ No / If YES, interpreter's name: / Interpreter's phone number: (_____) _____	Best time to call

PART II – MEDICAL INFORMATION

COUNTY USE ONLY

5. Have you applied for Social Security Disability or Supplemental Security Income (SSI) Disability benefits in the past two (2) years? ❒ Yes ❒ No

   If YES, please answer the following:

   a. Was/Is your Social Security or SSI Disability application:
      ❒ Approved? ❒ Denied? ❒ Pending? ❒ On Appeal? ❒ Unknown?

   b. If approved or denied, give the date of the most recent decision on your Social Security or SSI disability application: _____

   c. Has your medical problem(s) worsened since the date in 5b above? ❒ Yes ❒ No
      If YES, please explain: _____

   d. Do you have any NEW medical problem(s) since the date in 5b, above, which you did NOT have when your Social Security or SSI disability decision was made?
      ❒ Yes ❒ No If YES, what medical problem(s)? _____

6. List all medical problems (physical, mental or emotional) that keep you from working or taking care of your personal needs. (Please attach additional sheet, if necessary.)

MEDICAL PROBLEM(S)	WHEN DID IT START (Month/Year)

MC 223 (6/94)

SUPPLEMENTAL STATEMENT OF FACTS
MC 223

7. Have you received care in a clinic or hospital for your illness(es) or injury(ies) in the last 12 months? ❒ Yes ❒ No

COUNTY USE ONLY

If YES, please fully answer the following:

Name of clinic/hospital

Patient/clinic or member number | Clinic/hospital telephone number ( )

Name of doctor(s) seen

ADDRESS of clinic/hospital (number, street, suite) City State ZIP code

MC 220 Signed ❒

Date first seen | Date last seen | Date of next appointment

Reason for the visit(s)

Did you stay in the hospital overnight? ❒ Yes ❒ No

If YES, date(s) entered:_____ date(s) left:_____

Were you seen in the emergency room? ❒ Yes ❒ No

If YES, date(s) seen:_____

List *ALL* medicines received:_____

List *ALL* treatments received and the dates the treatments were received:_____

8. List any additional clinic or hospital where you have been seen in the last 12 months.

Name of clinic/hospital

Patient/clinic or member number | Clinic/hospital telephone number ( )

Name of doctor(s) seen

ADDRESS of clinic/hospital (number, street, suite) City State ZIP code

MC 220 Signed ❒

Date first seen | Date last seen | Date of next appointment

Reason for the visit(s)

Did you stay in the hospital overnight? ❒ Yes ❒ No

If YES, date(s) entered:_____ date(s) left:_____

Were you seen in the emergency room? ❒ Yes ❒ No

If YES, date(s) seen:_____

List *ALL* medicines received:_____

List *ALL* treatments received and the dates the treatments were received:_____

If you have been seen at additional clinics or hospitals in the last 12 months, complete page 8.

SUPPLEMENTAL STATEMENT OF FACTS
MC 223

9. Have you been seen by any doctor outside of the clinic(s) or hospital(s) you have already listed in the last 12 months? ❒ Yes ❒ No

COUNTY USE ONLY

If NO, go to number 10. If YES, please fully answer the following; if more than one doctor was seen, please complete page 8 for all additional information:

Name of doctor(s)

Patient/clinic or member number | Doctor's telephone number ( )

Address of doctor (number, street, suite) City State ZIP code

Date first seen | Date last seen | Date of next appointment

Reason for the visit(s)

List *ALL* medicines received:

List *ALL* treatments received and the dates the treatments were received:

MC 220 Signed ❒

10. Please list below if you have had any of the following tests in the last 12 months. Be sure to check yes or no next to each test. (IF ADDRESS OF DOCTOR, CLINIC, OR HOSPITAL WAS GIVEN ALREADY, LIST ONLY THE NAME AND DATE.)

TEST PERFORMED	YES	NO	NAME AND ADDRESS OF OFFICE, CLINIC, OR HOSPITAL WHERE TEST WAS COMPLETED	DATE (MO/YR)	
Electrocardiogram (EKG)			Name Address (number, street, suite) City State ZIP Code		MC 220 Signed ❒
Treadmill (exercise heart test)			Name Address (number, street, suite) City State ZIP Code		MC 220 Signed ❒
Chest X-ray			Name Address (number, street, suite) City State ZIP Code		MC 220 Signed ❒
Breathing Test (PFT)			Name Address (number, street, suite) City State ZIP Code		MC 220 Signed ❒
Blood Tests			Name Address (number, street, suite) City State ZIP Code		MC 220 Signed ❒
Other (Specify)			Name Address (number, street, suite) City State ZIP Code		MC 220 Signed ❒

SUPPLEMENTAL STATEMENT OF FACTS
MC 223

11. Have you had any other medical treatment or testing in the past 12 months? ❒ Yes ❒ No

If NO, go to number 12.

If YES, complete page 8.

COUNTY USE ONLY

12. Is there anyone else (a friend, relative, social worker, rehab counselor, attorney, physical therapist, etc.) we may contact for information regarding your illness or injury and how it limits your daily activities or keeps you from working? ❒ Yes ❒ No

If YES, please list below.

Name	
Address (number, street, suite)	
Telephone number ( )	Relationship to you
Name	
Address (number, street, suite)	
Telephone number ( )	Relationship to you
Name	
Address (number, street, suite)	
Telephone number ( )	Relationship to you

13. You may be asked to go to additional medical examinations to help evaluate your medical problem(s). (These examinations are free to you.)

Are you willing to go to additional medical examinations if needed? ❒ Yes ❒ No

PART III – SOCIAL AND EDUCATIONAL INFORMATION

14. Describe your daily activities and tell us how much your condition limits your activities.

_____

_____

_____

15. Describe your educational background.

a. Check the highest grade you finished in school:
❒ 1 ❒ 2 ❒ 3 ❒ 4 ❒ 5 ❒ 6 ❒ 7 ❒ 8 ❒ 9 ❒ 10 ❒ 11
❒ 12 or ❒ GED (same as finishing 12th grade) ❒ 12+

b. When finished? Month/year _____

c. Did you take special education classes? ❒ Yes ❒ No

16. Have you done any type of work for more than 30 days during the last 15 years? (This includes work done in another country.)

❒ Yes ❒ No

If NO, skip Part IV, go to Part V, page 7, for your signature.

If YES, answer Part IV, page 5, beginning with number 17.

SUPPLEMENTAL STATEMENT OF FACTS
MC 223

17b. Job Title | Type of business | *COUNTY USE ONLY*

Dates worked (month/year) From:_____ To:_____ | Hours per week | Rate of pay | Per hour/wk/mo

DESCRIPTION OF THE JOB (This is what I did and how I did it.)

These are the tools, machines, and equipment I used:

I took this long to learn the job: _____ day(s) or _____ month(s).
I wrote, completed reports, or performed similar duties: ❒ Yes ❒ No
I had supervisory responsibilities: ❒ Yes ❒ No

PHYSICAL ACTIVITY — Circle One

I walked this many hours in an average workday: 0 1 2 3 4 5 6 7 8
I stood this many hours in an average workday: 0 1 2 3 4 5 6 7 8
I sat this many hours in an average workday: 0 1 2 3 4 5 6 7 8

I climbed this much in an average workday:
❒ Never ❒ Occasionally ❒ Frequently ❒ Constantly

I bent over this much in an average workday:
❒ Never ❒ Occasionally ❒ Frequently ❒ Constantly

Heaviest weight I lifted: ❒ 10 lbs. ❒ 20 lbs. ❒ 50 lbs. ❒ Over 100 lbs.
I often lifted/carried up to: ❒ 10 lbs. ❒ 20 lbs. ❒ 50 lbs. ❒ Over 100 lbs.

Did you have any of your current medical problem(s) when you performed this job? ❒ Yes ❒ No

If NO, and you have had NO other jobs, go to Part V, page 7, for your signature. If NO, but you have had other jobs, ask your county worker for additional pages. If YES, please complete the following information.

Name of medical problem(s):_____

Did your employer make special arrangements (such as extra breaks, special equipment, change in job duties, etc.) so you could continue to work? ❒ Yes ❒ No

If YES, describe the special arrangements made: _____

Did you have to stop working because of your medical problem(s)? ❒ Yes ❒ No

If YES, when? Month_____ Day _____ Year _____

Have you done any other work for more than 30 days during the last 15 years? ❒ Yes ❒ No

If NO, go to Part V, page 7 for your signature. If YES, ask your county worker for additional pages to complete.

SUPPLEMENTAL STATEMENT OF FACTS
MC 223

PART V – SIGNATURE AND CERTIFICATION

I declare under penalty of perjury under the laws of the United States of America and the State of California that the information contained in this supplemental Statement of Facts is true and correct.

Signature of Applicant ➡	Date
Signature of Witness (If applicant signed with a mark) ➡	Date
Signature of person helping applicant fill out the form ➡	Date

You will need to sign an authorization for release of information for each clinic, hospital, and testing facility that you list and for each doctor you saw outside of a clinic or hospital. Your county worker will provide you with additional forms which you will need to sign.

SUPPLEMENTAL STATEMENT OF FACTS
MC 223

Continued answer(s) to question(s) number 8, page 2; number 9 on page 3; and number 10 on page 3.
If you need more room, please ask county staff for additional pages to complete.

List any additional clinic or hospital where you have been seen in the last 12 months.

Name of clinic/hospital

Patient/clinic or member number | Clinic/hospital telephone number ( )

Name of doctor(s) seen

ADDRESS of clinic/hospital (number, street, suite) City State ZIP code

Date first seen | Date last seen | Date of next appointment

Reason for the visit(s)

Did you stay in the hospital overnight? ❒ Yes ❒ No

If YES, date(s) entered:_____ date(s) left:_____

Were you seen in the emergency room? ❒ Yes ❒ No

If YES, date(s) seen:_____

List *ALL* medicines received:_____

List *ALL* treatments received and the dates the treatments were received:_____

MC 220 Signed ❒

List any additional doctor you saw outside of the clinic(s) or hospital(s) you have already listed.

Name of doctor(s)

Patient/clinic or member number | Doctor's telephone number ( )

Name of doctor(s) seen

ADDRESS of doctor (number, street, suite) City State ZIP code

Date first seen | Date last seen | Date of next appointment

Reason for the visit(s)

List *ALL* medicines received:_____

List *ALL* treatments received and the dates the treatments were received:_____

MC 220 Signed ❒

List any additional tests you have had in the last 12 months:

TEST PERFORMED	NAME AND ADDRESS OF OFFICE, CLINIC, OR HOSPITAL WHERE TEST(S) WAS COMPLETED	DATE (MO/YR)
	Name Address (number, street, suite) City State ZIP code	
	Name Address (number, street, suite) City State ZIP code	

MC 220 Signed ❒

MC 220 Signed ❒

SUPPLEMENTAL STATEMENT OF FACTS
MC 223

PART IV – WORK HISTORY

COUNTY USE ONLY

17. Describe all of the jobs you have done for at least 30 days during the last 15 years. Start with your most recent job. (If you had more than two jobs, ask your county worker for additional pages.)

a. Job Title	Type of business
Dates worked (month/year) From:_____ To:_____	Hours per week Rate of pay Per hour/wk/mo

DESCRIPTION OF THE JOB (This is what I did and how I did it.)

These are the tools, machines, and equipment I used:

I took this long to learn the job: _____ day(s) or _____ month(s).
I wrote, completed reports, or performed similar duties: ❒ Yes ❒ No
I had supervisory responsibilities: ❒ Yes ❒ No

PHYSICAL ACTIVITY	Circle One
I walked this many hours in an average workday:	0 1 2 3 4 5 6 7 8
I stood this many hours in an average workday:	0 1 2 3 4 5 6 7 8
I sat this many hours in an average workday:	0 1 2 3 4 5 6 7 8

I climbed this much in an average workday:
❒ Never ❒ Occasionally ❒ Frequently ❒ Constantly

I bent over this much in an average workday:
❒ Never ❒ Occasionally ❒ Frequently ❒ Constantly

Heaviest weight I lifted: ❒ 10 lbs. ❒ 20 lbs. ❒ 50 lbs. ❒ Over 100 lbs.

I often lifted/carried up to: ❒ 10 lbs. ❒ 20 lbs. ❒ 50 lbs. ❒ Over 100 lbs.

Did you have any of your current medical problem(s) when you performed this job? ❒ Yes ❒ No

If NO, and you have had NO other jobs, go to Part V, page 7, for your signature. If NO, but you have had other jobs, go to 17b, next page. If YES, please complete the following information.

Name of medical problem(s):_____

Did your employer make special arrangements (such as extra breaks, special equipment, change in job duties, etc.) so you could continue to work? ❒ Yes ❒ No

If YES, describe the special arrangements made: _____

Did you have to stop working because of your medical problem(s)? ❒ Yes ❒ No

If YES, when? Month_____ Day _____ Year _____

Have you done any other work for more than 30 days during the last 15 years? ❒ Yes ❒ No

If NO, go to Part V, page 7 for your signature. If YES, continue on 17b, next page.

DED PENDING INFORMATION UPDATE
MC 222

STATE OF CALIFORNIA – HEALTH AND WELFARE AGENCY

DEPARTMENT OF HEALTH SERVICES

DED PENDING INFORMATION UPDATE

COUNTY WELFARE DEPARTMENT ADDRESS

DED ADDRESS

Los Angeles State Disability Program
P. O. Box 30541, Terminal Annex
Los Angeles, CA 90030-9934

County No. Aid Case Case No.
_ _

Social Security No. _ _
on MC221 _____

Applicant's Name
(Last, First, MI) _____

_ _
Date of Birth _____

THIS FORM MUST BE USED WHEN A DED PACKET IS PENDING AT DED AND CHANGED/ADDITIONAL INFORMATION NEEDS TO BE SUBMITTED TO DED (DO NOT USE MC 221 TO REPORT CHANGES OR TO UPDATE INFORMATION)

Check the appropriate box or boxes and complete the information

1. ☐ CHANGE OF ADDRESS
   New Address: _____
2. ☐ CHANGE OF TELEPHONE NO.
   New Telephone No.: ( ) _____
3. ☐ CHANGE OF SOCIAL SECURITY NO.
   Corrected No.: _ _ _____
4. ☐ CASE CLOSED
   Date: _____ (Discontinue Evaluation)
5. ☐ CLIENT DECEASED
   Death Certificate Attached ☐ Yes ☐ No
6. ☐ NON ENGLISH SPEAKING
   Language Spoken: _____
   Interpreter Name: _____ Phone No.: ( ) _____
7. ☐ UPDATED MEDICAL RECORDS ATTACHED
8. ☐ CHANGE OF COUNTY WORKER (See Below)
9. ☐ OTHER _____

Worker Name: (Please Print)	Worker Number:
Date:	Telephone Number: ( )

MC 222 LA (4/93)

REDETERMINATIONS/REEVALUATIONS/REEXAMINATIONS

REFERRAL	WHEN USED (CRITERIA)	WHAT TO INCLUDE	ELIG. PENDING DED RESP.
Reexamination	An evaluation of disability to see if medical improvement has occurred, to be used when one of the following occurs: ❍ DDSD has established a re-exam date; or ❍ Client becomes employed; or ❍ Other circumstances lead the worker to believe condition has improved.	❍ A complete DDSD packet. ❍ A new MC 221 marked "Re-examination." (State the reason for reexamination in the Comments Section.) ❍ A copy of prior MC221 and a copy of the prior DDSD determination. ❍ Any new medical records.	Eligibility continues UNLESS: ❍ The client fails to cooperate with DDSD; ❍ Whereabouts unknown; ❍ DDSD decides client is no longer disabled and there is no other linkage; or, ❍ Another reason for discontinuance exists.
Redetermination	Use when an applicant meets all of the following criteria: ❍ Previously received Medi-Cal as a disabled person; ❍ Was discontinued for a reason other than disability; and ❍ Was previously determined disabled by DDSD.	❍ A new MC 221 marked "Redetermination." (State Redetermination after break in aid in the Comments Section.) ❍ A copy of prior MC 221 and prior DDSD determination. ❍ Use a **limited DDSD packet** if MC discontinuance occurred within 12 months or less. ❍ Use a **complete DDSD packet** if: MC discontinuance occurred over 12 months ago; reexam date is unknown, due or past due; client's condition is improved; SSA claim is pending; **or** SSA denial is more than 12 months ago.	❍ Eligibility cannot be established until DDSD decision is received, unless applicant meets "presumptive" disability criteria or until eligibility is established under another category.
Reevaluation	Used when the worker believes that the DDSD denial is incorrect and within 90 days of DDSD's decision: ❍ DDSD independently reviewed claim and the worker believes DED was unaware of medical evidence, conditions or recent events which could affect the decision, OR; ❍ DDSD adopted an SSA denial and the client has totally new medical condition that was not previously considered by SSA and the client is not appealing SSA's decision. (If DDSD adopted an SSA denial and the applicant alleges his/her condition has worsened or has new medical evidence which was not previously considered, do NOT do a new DDSD packet. Send back to SSA to appeal if SSA's decision was made within 12 months.)	❍ A new MC 221 marked "Reevaluation." (State reason for reevaluation in Comments Section.) ❍ A copy of prior MC 221 and prior DDSD determination. ❍ Any new medical reports. ❍ Use a **limited DDSD packet** if packet is sent within 30 days of SP-DDSD's non SSA decision or an earlier onset date on an approved case is needed, and there is no new medical evidence. ❍ Use a **complete DDSD packet** if packet is sent 31 to 90 days of SP-DDSD's non SSA decision and client's condition has worsened or a new medical condition exists.	❍ Eligibility cannot be established until DDSD completes the reevaluation.

DED RESPONSE CODES

CODE	DESCRIPTION
A	ALLOWANCE
A61	MEETS LISTING
A62	EQUALS LISTING
A63	MEDICAL AND VOCATIONAL FACTORS
A64	MEDICAL, VOCATIONAL, ARDUOUS
A65	CONTINUANCE DECISION FOR A RCR
A98	ADOPTION IN STATE HEARING CASE
A99	ALLOWANCE - NO CODE AVAILABLE
B61	STATUTORILY BLIND
D	DENIED
N	NO DETERMINATION
N22	AN INMATE OF A PUBLIC INSTITUTION
N23	NOT A RESIDENT OF THE UNITED STATES
N24	FELONY CONVICTION OF FRAUDULENTLY MISREPRESENTING RESIDENCE IN ORDER TO RECEIVE BENEFITS SIMULTANEOUSLY IN TWO OR MORE STATES
N25	FLEEING PROSECUTION OF A FELONY OR VIOLATING A CONDITION OF PROBATION OR PAROLE
N30	NON-SEVERE DENIAL
N31	CAPACITY FOR PAST WORK
N32	CAPACITY FOR OTHER SGA
N34	DID NOT MEET DURATION
N35	WILL NOT MEET DURATION
N37	FAILURE TO ATTEND CE (CONSULTATIVE EXAM)
N38	APPLICANT WITHDRAWAL
N39	FAILURE TO FOLLOW TREATMENT
N40	DOES NOT MEET OR EQUAL
N41	NON SEVERE - VISUAL DENIAL
N42	CAPACITY FOR PAST WORK - VISUAL
N43	CAPACITY FOR OTHER SGA - VISUAL
N45	DID NOT MEET DURATION - VISUAL
N46	WILL NOT MEET DURATION - VISUAL
N51	DOES NOT MEET OR EQUAL - VISUAL
N55	CESSATION DECISION ON AN RCR
Z49	NO-INTERVIEW SCREEN-OUT
Z53	OTHER DENIAL
Z54	WITHDRAWAL BY CWD
Z55	REFERRED IN ERROR
Z56	OTHER NO DETERMINATION
Z57	OTHER NO DETERMINATION IN RCR
Z58	INAPPROPRIATELY DIARIED RCR'S

GUIDELINES TO REQUESTING MEDICAL RECORDS

This is a guide to assist counties who wish to expedite a client's case by obtaining or requesting medical evidence specific to the client's impairments. The information is required for evaluation of Medi-Cal disability cases and helps to avoid the need for a consultative examination.

NOTE: UNDER NO CIRCUMSTANCES ARE THE COUNTIES TO DELAY SENDING DISABILITY PACKETS TO SP-DED PENDING RECEIPT OF MEDICAL RECORDS OR DENY THE APPLICATION FOR FAILURE TO PROVIDE THE RECORDS.

Requirements by Body System

MUSCULOSKELETAL SYSTEM – Fractures, Back, Arthritis

- Admission Summaries
- Discharge Summaries, if available
- History/Physical Examinations
- Surgical Reports
- X-Ray Reports – If serial x-rays are available, only the earliest and latest results are needed.
- Laboratory Reports – in cases involving inflammatory or rheumatoid arthritis
- Medical and surgical notes describing pain, range of motion, atrophy, sensory motor, reflex changes, gait disturbances, and functional restrictions.

SPECIAL SENSE ORGANS – Vision, Hearing & Speech

- Admission Summaries
- Discharge Summaries, if available
- History/Physical Examinations
- Surgical Reports
- Sight: Central visual acuity before and after best correction; and visual field charts
- Hearing: Audiograms – aided/unaided; speech discrimination tests; and electronystagmography (ENG)

Because of the special provisions for the disabled blind claimant, the record of the earliest date the individual became statutorily blind is essential – i.e. the first date visual acuity in the better eye with correction was only 20/200 or less.

RESPIRATORY SYSTEM – Bronchitis, Emphysema, COPD, Asthma, TB

- Admission Summaries
- Discharge Summaries, if available
- History/Physical Examinations
- Restrictive and Obstructive Disorders
  Chest x-ray reports – Upright films are preferable. If serial x-rays are available, only the earliest and latest results are needed.
- Bronchograms
- PFT – with spirograph (tracings) before and after bronchodilators
- Blood gas studies and/or diffusion studies at rest and at exercise
- Culture Reports – if any are available

CARDIOVASCULAR SYSTEM – Heart Disease

- Admission Summaries
- Discharge Summaries, if available
- History/Physical Examinations
- EKG tracings (especially if documentation of M.I.) with interpretation and tracings
- Reports of serial enzymes
- Exercise (Treadmill) EKG (TET) with Tracings
- Thallium Scans
- Angiogram
- Coronary catheterization
- Echocardiogram
- CBC
- Chest X-Ray
- Description of Chest Pain

PERIPHERAL VASCULAR DISEASE

- Same information as listed above for Cardiovascular System
- Oscillometry – Doppler with exercise if available
- Arteriography
- Laboratory Reports (earliest and latest results are needed)
- If serial x-rays, only the earliest and latest results are needed.

DIGESTIVE SYSTEM – Liver, Ulcers, Colitis

- Admission Summaries
- Discharge Summaries, if available
- History/Physical Examinations
- Surgical Reports
- Height and Weight

- X-Ray Reports – If serial x-rays are available, only earliest and latest results are needed.
- Laboratory Reports (serial liver function tests over 5+ months)
- Malabsorption stool tests
- Reports on any endoscopic procedures

GENITOURINARY SYSTEM – Kidney Failure

- Hemodialysis – any records, whether undertaken or planned
- Any indication whether dialysis is chronic or acute
- Any indication of the need for a kidney transplant
- Serum creatinine or creatine clearance tests
- Renal Biopsy Reports
- Sonograms
- Renal Profusion Studies
- CBC
- Weight & Height
- IV Pyelogram
- Cystoscopic examination
- X-Ray Reports – If serial x-rays are available, only the earliest and latest results are needed.

HEMIC AND LYMPHATIC SYSTEM – Anemia, Sickle Cell, Leukemia

- All Laboratory Work – especially serial hematocrit
- Sickle Cell Anemia – any documentation of thrombotic crisis hemorrhage or blood clots.
- X-Ray reports
- Any Pathology Reports

SKIN

- Admission Summaries
- Discharge Summaries, if available
- History/Physical Examinations
- Dermatological Report
- Progress Notes
- Biopsy Reports

ENDOCRINE AND OBESITY SYSTEMS

- Admission Summaries
- Discharge Summaries, if available
- History/Physical Examinations
- Laboratory Studies
- X-Rays for Osteoporosis and Osteoarthritis
- Neurological Examination

- Ophthalmological Examination
- Surgical Reports
- Doppler Tests
- Arteriogram
- Height and Weight
- Description of Limitation of Motion or Functional Limitation
- Chest X-Rays
- PFT with Tracings

NERVOUS SYSTEM

Common Conditions: Epilepsy, CVA, Brain Tumors, Cerebral Palsy, Parkinson's Disease, Multiple Sclerosis, Polio, Spinal Cord Injury

- Admission Summaries
- Discharge Summaries, if available
- History/Physical Examinations
- Neurological Examinations
- EEG
- Anti-convulsant blood levels
- CT Scans and X-Rays
- Psychological Examinations
- Surgical Reports
- Muscle biopsy
- EMG
- Nerve conduction test

MENTAL DISORDERS

- Psychiatric Evaluation
- Psychological test results
- Psychological evaluations
- All records (including Admission and Discharge Summaries) of all hospitalizations or treatments during the past (four) 4 years.
- Description of daily activities and function levels
- List of all prescribed medication
- History of drug, alcohol use or dependence

NEOPLASTIC DISEASES – Cancer

- Admission Summaries
- Discharge Summaries, if available
- History/Physical Examinations
- Biopsy and surgical pathological reports
- Surgical Reports

- CAT Scans, MRI
- Chemotherapy, radiation effects
- Laboratory Reports
- Tumor Board Recommendations

IMMUNE SYSTEM – HIV Infection, AIDS, Systemic Lupus, Scleroderma, Connective Tissue Disorder, Vasculitis, Polymyositis

- Admission Summaries
- Discharge Summaries, if available
- History/Physical Examinations
- Laboratory Reports (blood tests, stool tests)
- Biopsy Reports
- Microscopy (histology, cytology, pathology)
- IV test (antibody, antigen, cultures)
- Other Cultures (sputum tests)
- PFTs
- Blood Gas Studies
- Neurological Exams
- Angiography
- Clinical findings cognitive/motor dysfunction
- Weight loss with diarrhea/weakness/fever – (Height and Weight)
- Brain imaging
- Description of how fatigue impacts activities of daily living
- Psychological Evaluations and Test Results
- History of drug and alcohol abuse

DDSD PACKET REVIEW CHECKLIST

The use of this checklist will help to reduce disability packet returns from DDSD by ensuring that all forms are present and correctly completed.

A. MC 221 (1/00 revision) - See the Medi-Cal Eligibility Procedures Manual Section 22 4.5/7

( ) Is the CWD address on all three copies?
( ) Is the case number included?
( ) Is the disabled applicant's first, middle and last name in item #1? Do not include the spouse's name or parent's name in item #1.
( ) Does item #5 include the month/day/year, and Retro Onset, if needed?
( ) If the case is a resubmitted packet, has a new MC 221 been prepared?
( ) If the case is a resubmitted packet, is a copy of the prior MC 221 and prior DDSD determination attached?
( ) If the request is a reexamination, redetermination or reevaluation, is additional information, regarding the request, provided in item #10?
( ) If there are any unavoidable omissions in the packet (e.g., missing address information for an out of state medical source which the client cannot provide), has an explanation as to why the information cannot be provided been stated in item #10?
( ) If a reopening is being requested because of a hearing remand, is a copy of the complete Administrative Law Judge's (ALJ) order attached and is an explanation for the ALJ's decision written in item #10?

B. MC 223 (6/94 revision) – See the Medi-Cal Eligibility Procedures Manual Section 22 C-4.7/11

( ) Has the MC 223 been thoroughly completed?
( ) Has item #6 been completely filled in with all of the applicant's alleged medical problem(s)? (Do not write "see attached" or "see medical records," etc.)
( ) Are complete addresses and dates of treatment (at least month/year) given for each source listed in items #7-10 and on page 8? If the information is unobtainable, is an explanation provided?
( ) Is item #15 completely filled in with the applicant's educational background and level of education?
( ) Are all the applicant's jobs for the past 15 years filled in in items #16-17? (Job title, job descriptions and the exact or best estimate of the applicant's past wages are necessary.)
( ) Is an English translation provided if a MC 223 Spanish form is being used? If the entire form is not translated, is there an English translation of item #6?

C. MC 220 (4/03 revision) – See the Medi-Cal Eligibility Procedures Manual Section 22 C-4.2/5

( ) Is there a sufficient number of MC 220s in the packet to cover every source listed on the MC 223, items #7-10 and on page 8?
( ) If the release of information is for a minor age twelve and over, living with parents and not applying for Minor Consent Medi-Cal, has the minor signed the releases in addition to separate releases signed by the parent?
( ) Are all MC 220s signed and dated by the applicant? If not, **indicate** specific physical or mental incapacity that prevents the applicant from signing **and** specify the relationship of the person signing for the applicant on the release.
( ) Are the MC 220s signed with an X or an unrecognizable symbol? If so, the MC 220s must also be signed and dated by a witness and the complete address of the witness must be included on the release.
( ) If the applicant is deceased, send death certificate and/or hospital admission notes with **reason for death and the doctor's signature**; otherwise send a complete packet.